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ABSTRACT

Most school districts employ student support or "pupil services professionals," such as school psychologists, counselors, and social workers. These personnel perform services connected with mental health and psychosocial problems. The format usually is a combination of centrally based and school-based services. Amelioration of the full continuum of student problems requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. This training tutorial is designed with self-directed opportunities for more in-depth learning about the variety of student and family assistance programs that address barriers to learning. It is divided into three sessions on why and how schools provide student and family assistance; understanding when specialized assistance is needed; and when the school should refer students and families to community resources. The tutorial is organized topically, with readings and related activities for preparation, active learning, and follow-up. (GCP)

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Mental Health in Schools
Center
Training and Technical Assistance

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A Center Training Tutorial . . .

Training Tutorial

STUDENT & FAMILY ASSISTANCE PROGRAMS AND SERVICES TO ADDRESS BARRIERS TO LEARNING

This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website http://smhp.psych.ucla.edu.

This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563 (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu
Website: http://smhp.psych.ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

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CG031674

The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with development, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.

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Continuing Education Modules & Training Tutorials: Self-directed opportunities to learn

In addition to offering *Quick Training Aids*, the Center's *Continuing Education Modules* and *Training Tutorials* are designed as self-directed opportunities for more in-depth learning about specific topics. These resources provide easy access to a wealth of planfully organized content and tools that can be used as a self-tutorial or as a guide in training others. As with most of our resources, these can be readily downloaded from our website – http://smhp.psych.ucla.edu – see Center Materials and scroll down to VI.

In the coming years, the Center will continue to develop a variety of continuing education modules and training tutorials related to the various topics covered by our Clearinghouse. In all its work, the Center tries to identify resources that represent "best practice" standards. We invite you to browse through this first set of modules and tutorials, and if you know of better material, please provide us with feedback so that we can make improvements.

CONTINUING EDUCATION MODULES

- *Addressing Barriers to Learning: New Directions for Mental Health in Schools*
- *Mental Health in Schools: New Roles for School Nurses*
- *Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling* (has an accompanying set of readings & tools)

TRAINING TUTORIALS

- *Classroom Changes to Enhance and Reengage Students in Learning*
- *Support for Transitions*
- *Home involvement in Schooling*
- *Community Outreach*
- *Crisis/Emergency Assistance and Prevention*
- *Student and Family Assistance*
- *Creating an infrastructure for an Enabling (Learning Support) Component to address barriers to student learning*

Using the Modules and Tutorials to Train Others

A key aspect of building capacity at schools involves ongoing staff and other stakeholder learning and development.* Those who are responsible for facilitating the training of others can use the Center's Continuing Education Modules and Training Tutorials to upgrade their repertoire and as resources in providing stakeholder training opportunities. With respect to training others, below are a few general reminders.

- *Start where they're at.* Good learning and teaching experiences are built on the concept of a good "match" (or "fit"). This involves both capabilities *and* interest (e.g., motivational readiness). From this perspective, it is essential to work with learner perceptions about what they want to learn and how they want to learn it. Thus, you might begin by finding out from those at the school:

  - ✓ What are their most pressing concerns (e.g., what range of topics are of interest, and within a broad topic, what subtopics would be a good starting point)?
  - ✓ How deeply do they want to cover a given subject (e.g., brief overview or in-depth)?
  - ✓ How would they like to organize learning opportunities?

  Also, in terms of a good match, it is invaluable to capitalize on "teachable moments." Occurrences frequently arise at a school that result in the need for staff to learn something quickly. These teachable moments provide opportunities to guide staff to the type of resources included in the Continuing Education Modules and Training Tutorials. These resources can be drawn upon to create displays and provide handouts and then following-up by engaging staff in discussions to explore relevant experiences and insights.

- *"Preheat" to create interest.* Do some "social marketing." Put up some displays; provide prospective learners with a few interesting fact sheets; hold a brief event that focuses on the topic.

- *Active Learning.* Although reading is at the core of the modules and tutorials, active learning and doing is essential to good learning. Active learning can be done alone or in various group configurations. The point is to take time to think and explore. Study groups can be a useful format. Individual and group action research also provides application opportunities.

- *Follow-up for ongoing learning.* Provide information on resources for ongoing learning. Plan ways to offer follow-up discussions and exploration in general and in personalized ways with those who want and need more.

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*There is a great deal of material discussing ways to pursue effective staff development in schools. An organization that is devoted to this arena is the National Staff Development Council (NSDC). It's library of information (see – http://www.nsdc.org/educatorindex.htm) provides guidelines, tools, and access to the *Journal of Staff Development*. The organization's emphasis is on a "how-to" format, offering a variety of effective, step-by-step models developed by practitioners who base their methods on research and real-world experiences.

TRAINING TUTORIAL

The Center's Training Tutorials are organized topically, with readings and related activities for "preheating," active learning, and follow-up. All readings and activity guides are available on the website of the national *Center for Mental Health in Schools* at UCLA

http://smhp.psych.ucla.edu

STUDENTS & FAMILY ASSISTANCE PROGRAMS AND SERVICES TO ADDRESS BARRIERS TO LEARNING

Overview Guide

	Page
Initial Resources to "Preheat" Exploration of this Matter	1
>*Developing Systems at a School for Problem Identification, Triage* Referral & Management of Care (from: *School-Based Client Consultation, Referral, and Management of Care*er - intro page and pp. 4-6)	2
>*Students and Families with Problems interfering with learning: What's a School to Do?* (Tutorial flyer)	7

Learning Sessions

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Readings.	From: *Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders, and Perspectives for Prevention and Treatment – Part II A full range of programs to address behavioral, emotional, and learning problems* (pp. II-1-14)	9
	Mechanisms for Delivering Mental Health in Schools (newsletter article)	24
Activity.	Use the various attached materials as stimuli and tools to focus application of what has been read	
	(1) *Outline What Has Been Learned so Far* – Make a list of the various ways that schools can provide specialized assistance for problems students and families are experiencing (use attached worksheet)	31
	(2) *What would you add?* (Use the attached guide sheet and the accompanying sections from the self-study survey entitled: *Student and Family Assistance Programs and Services*)	32
	(3) *Discussion Session Exploring Outline of What has been Learned* (see the attached guide sheet for ideas about forming an informal discussion and/or a formal study group)	33

Topic 2: *Understanding when specialized assistance is needed* 34

Readings. From: *Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders, and Perspectives for Prevention and Treatment – I. Keeping the environment in perspective as a cause of commonly identified psychosocial problems* (pp. I-1-6) 35

About Talking with Kids (newsletter article) 42

Activity. Use the various attached materials as stimuli and tools to focus application of what has been read

(1) *Outline and Discuss What Has Been Learned so Far* – How do you the various reasons students might have learning, behavioral, and emotional problems? (use attached worksheet) 43

(2) *Interviewing to Determine a Student's View of the Problem* (see attach worksheet) 44

(3) *Review Screening Tools* (see attached introduction to a Resource Aid Packet) 52

Topic 3: *When should the school refer students and families to community resources?* 57

Reading. From: *School-Based Client Consultation, Referral, and Management of Care* (pp. 12 - 37) 58

Activity. Use the various attached materials as stimuli and tools to focus application of what has been read

(1) *Write and Discuss* – Using Pre-referral Interventions (use the attached worksheet as an activity guide) 85

(2) *Write and Discuss* – Referral Intervention Guidelines (use the attached worksheet as an activity guide) 92

Follow-Up for Ongoing Learning

As you decide to learn more about these matters, the following Center resources should be a helpful next step.

(1) The ***Quick Finds*** section of the Center website offers topic areas that are regularly updated with new reports, publications, internet sites, and centers specializing in the topic. Stakeholders can keep current on *Student and Family Assistance Programs and Services to Address Barriers to Learning* by visiting topic areas such as:

>Anger Management
>Case Management
>Chronic Illness
>Domestic violence
>Grief
>Memo of Agreement
>PTSD
>Substance Abuse
>Anxiety
>Child Abuse/Neglect
>Conduct Disorders
>Eating Disorders
>Homeless Children
>MH Curriculum
>School Avoidance
>Suicide Prevention
>ADHD
>Children and poverty
>Confidentiality
>Disturbed children
>Juvenile justice
>MH in schools
>School Linked Ser.
>Systems of Care
>Bullying
>Children of Alcoholics
>Depression
>Family Counseling
>Medicaid
>Oppositional
>Student & Fam. Assist.
>Teen Pregnancy

(2) Consider forming ongoing study groups on this subject.

(3) Request ongoing inservice training on related matters.

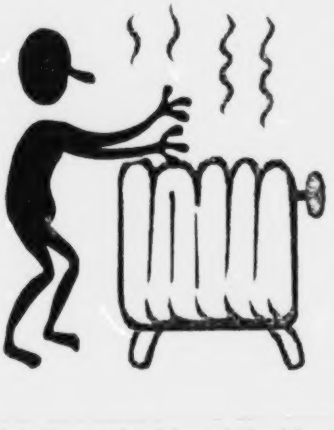
Initial Resources to "Preheat"
Exploration of this Matter

The following materials provide a brief introduction and overview tot he ideas covered by the tutorial

Developing Systems at a School for Problem Identification, Triage, Referral & Management of Care (from: *School-Based Client Consultation, Referral and Management of Care* - intro page and pp. 4-6)

In readying others for training in this matter, display the attached flyer and the above article on a training bulletin board and provide copies to interested staff

Student Families with Problems Interfering with Learning: What's a School to Do? (Tutorial flyer)



Source: UCLA Center for Mental Health in Schools: Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

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Excerpt From

From the Center's Clearinghouse ...[*]

A Technical Aid Packet on

School-Based Client Consultation, Referral, and Management of Care

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Everyone would do well to gain a bit of consumer savvy before contacting a professional resource -- not because professionals are out to rip people off (although there are a few shady practitioners in any profession) but because the majority of professional services by their very nature have built-in biases and usually reflect prevailing treatment dogma.

Practitioners often promote only one view of a problem and the needed treatment, and may also use confusing jargon or perhaps overly complex or unproven theories and practices.

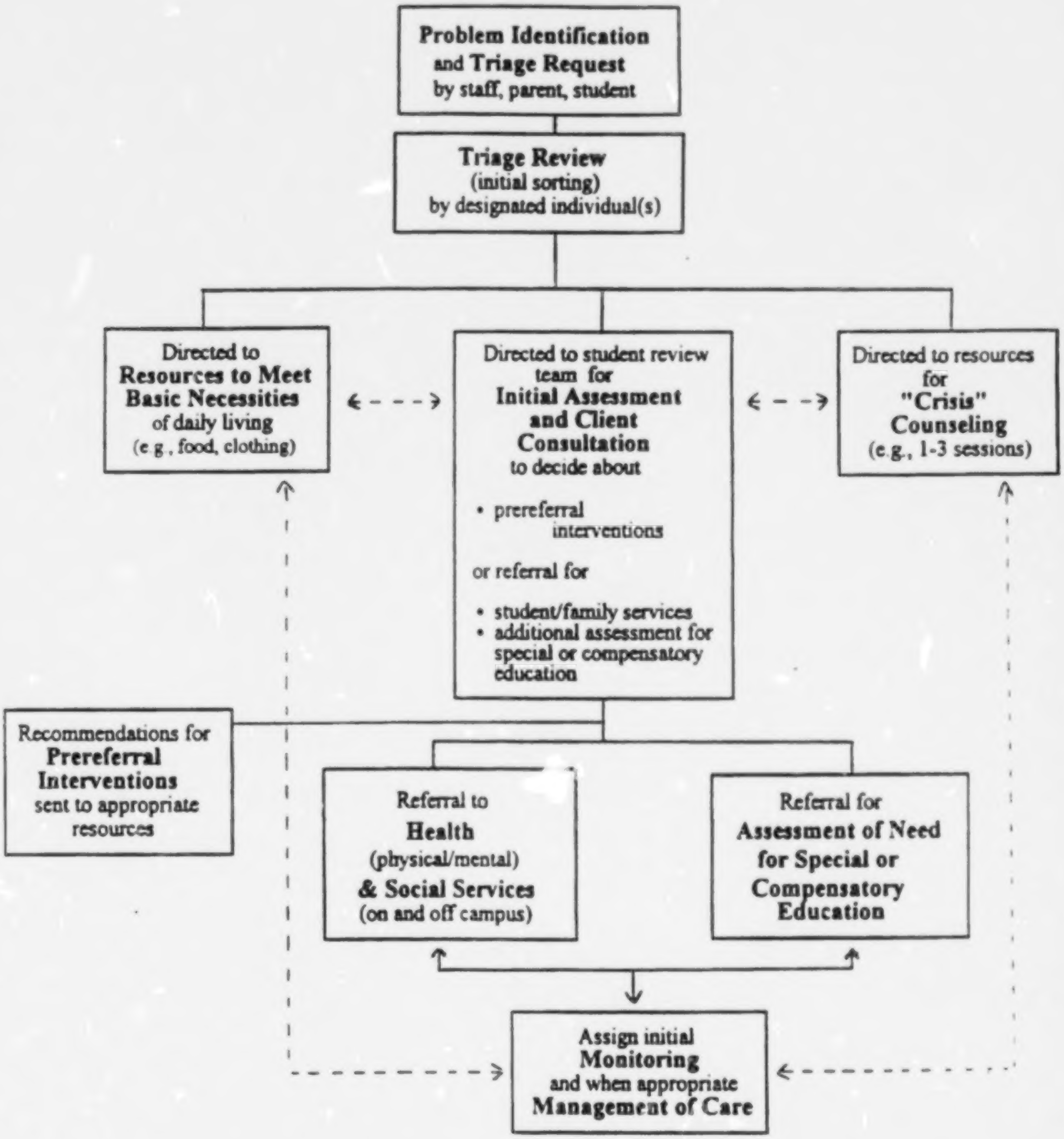
In looking for help the consumer's problem is twofold:

to identify feasible resources

and then

to evaluate their appropriateness.

Problem Identification, Triage, Assessment and Client Consultation, Referral, and Management of Care


Problem Identification and Triage Request by staff, parent, student
Triage Review (initial sorting) by designated individual(s)
Directed to Resources to Meet Basic Necessities of daily living (e.g., food, clothing)
Directed to student review team for Initial Assessment and Client Consultation to decide about • prereferral interventions or referral for • student/family services • additional assessment for special or compensatory education
Directed to resources for "Crisis" Counseling (e.g., 1-3 sessions)
Recommendations for Prereferral Interventions sent to appropriate resources
Referral to Health (physical/mental) & Social Services (on and off campus)
Referral for Assessment of Need for Special or Compensatory Education
Assign initial Monitoring and when appropriate Management of Care

Guidelines

Problem Identification, Triage, Assessment and Client Consultation, Referral, and Management of Care

Problem Identification and Triage Request

- Problems may be identified by anyone (staff, parent, student)
- There should be a Triage Request Form that anyone can access and fill out.
- There must be an easily acceptable place for people to turn in Triage Requests.
- Everyone should be informed of the process for making a Triage Request and what follows such a request.

Triage Review

- Several individuals should be designated and trained to review, sort, and direct forms every day to appropriate resources. These individuals can work independently of each other in sharing the task. For example, different individuals can do reviews on specified days or for an entire week.
- After the sorting is done, the reviewer should send a status information form to the person who identified the problem (assuming it was not a self-referral).

Students/Families Directed to Resources or for Assessment and Client Consultation

- For resources to meet the basic necessities of daily living (e.g., food, clothing), the triage reviewer should provide the student/family with information directly or through the person who identified the problem.
- If a problem clearly requires immediate counseling for a few sessions to help a student/family through a crisis, the triage reviewer should direct the form to the appropriate person designated to make assignments to available on-site crisis counselors.
- All other forms are directed to a small student review "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large number of requests for such reviews, several teams might be put into operation.) Members of such a team might not meet on all cases since some can be reviewed independently with recommendations made and passed on to subsequent reviewers for validation or revision. For complex problems, however, the team will have to meet and probably will need to gather more information from various involved parties (e.g., teacher, parent, student).
- All analyses and recommendations are shared with the student/family during a client consultation session at which decisions are made about appropriate course of action (e.g., referrals).

Prereferral Interventions, Referral for Assessment to Qualify for Special Services, or Referral to Health and Social Services

- In many instances, "prereferral interventions" should be tried. This requires that the school has or develops the type of resources that can be used to help classroom teachers learn and try new strategies. By monitoring the impact of such interventions, it can be decided whether they are sufficient for handling the problem. At the very least, they will provide additional data on what isn't working and what might.

- When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Initial monitoring should be designed to determine follow-through and possible need for additional referrals.

- Referrals for assessment to determine need for special or compensatory education often are delayed because of a waiting list. Back logs must be monitored procedures used to reduce delays (e.g., by arranging for 1-2 days of intensive assessment and review).

Management of Care

- Some situations require only initial monitoring (e.g., to ensure follow-through). Persons must be identified and trained to function as such monitors and a system developed for assigning them as needed.

- Other situations require ongoing management of care to ensure
    (a) interventions are coordinated, integrated, and appropriate
    (b) problem analysis is ongoing
    (c) intervention impact is evaluated
    (d) interventions are revised as needed
    and so forth.

  There are many models for managing care. For example, one common approach is to assign the primary responsibility for managing care to the professional who has the greatest involvement (or best relationship) with the student/family. All potential managers of care need training for the role.

- One key and often neglected function of the person with primary responsibility for managing care is to provide appropriate status updates to *all* parties who should be kept informed (e.g., teachers, administrators).

Flyer

Students Families with Problems Interfering with Learning: What's a School to Do?

How to listen so kids will talk ... and then what to do?

What our school can provide?

What our community can provide?

Want to learn more?

See the brief articles that have been posted____________.

Join in a tutorial on:

STUDENTS AND FAMILY ASSISTANCE PROGRAMS AND SERVICES TO ADDRESS BARRIERS TO LEARNING

Time:

Place:

Topic 1: Why and how schools provide student and family assistance to address barriers to learning.

Reading & Activity

Readings. From: *Common Psychosocial Problems of School Aged youth: Developmental Variations, Problems, disorders, and Perspectives for Prevention and Treatment - Part II A full range of programs to address behavioral, emotional, and learning problems.*

Mechanisms for Delivering Mental Health in Schools (newsletter article)

Activity. Use the various attached materials as stimuli and tools to focus application of what has been read.

(1) *Outline What Has Been Learned so Far* – Make a list of the various ways that schools can provide specialized assistance for problems students and families are experiencing (use attached worksheet)

(2) *What would you add?* (Use the attached guide sheet and the accompanying sections from the self-study survey entitled: *Student and Family Assistance Programs and Services*)

(3) *Discussion Session Exploring Outline of What has been Learned* (see the attached guide sheet for ideas about forming an informal discussion and or a formal study group)

Mental Health in Schools
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Excerpt From

GUIDEBOOK:

Common Psychosocial Problems of School Aged Youth:

Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment

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II. A FULL RANGE OF PROGRAMS TO ADDRESS BEHAVIORAL, EMOTIONAL, AND LEARNING PROBLEMS

Amelioration of the full continuum of problems, requires a comprehensive and integrated programmatic approach. Such an approach may require one or more mental health, physical health, and social services. That is, any one of the problems may require the efforts of several programs, concurrently and over time. This is even more likely to be the case when an individual has more than one problem. And, in any instance where more than one program is indicated, it is evident that inter-ventions should be coordinated and, if feasible, integrated.

A. A Continuum of Community-School Programs: Primary Prevention through Treatment

To illustrate the comprehensive range of programs needed, a continuum is outlined on the following page. The continuum ranges from programs for primary prevention (including the promotion of mental health) and early-age intervention -- through those for addressing problems soon after onset -- on to treatments for severe and chronic problems. With respect to *comprehensiveness,* the range of programs highlights that many problems must be addressed developmentally and with a range of programs --some focused on individuals and some on environmental systems, some focused on mental health and some on physical health, education, and social services. With respect to concerns about *integrating* programs, the continuum underscores the need for concurrent inter-program linkages and for linkages over extended periods of time.

When behavior, emotional, and learning problems are labeled in ways that overemphasize internal pathology, the helping strategies used primarily are some form of clinical/remedial intervention. For the most part, such interventions are developed and function in relative isolation of each other. Thus, they represent another instance of using piecemeal and fragmented strategies to address complex problems. One result is that an individual identified as having several problems may be involved in programs with several professionals working independently of each other.

Caution:

As community agencies and schools struggle to find ways to finance programs for troubled and troubling youth, they continue to tap into resources that require assigning youngsters labels that convey severe pathology. Reimbursement for mental health and special education interventions is tied to such diagnoses. This fact dramatically illustrates how social policy shapes decisions about who receives assistance and the ways in which problems are addressed. It also represents a major ethical dilemma for practitioners. That dilemma is not whether to use labels, but rather how to resist the pressure to inappropriately use those labels that yield reimbursement from third party payers.

From Primary Prevention to Treatment of Serious Problems: A Continuum of Community-School Programs

Intervention Continuum

Examples of Focus and Types of Intervention

(Programs and services aimed at system changes and individual needs)

Primary prevention

1. *Public health protection, promotion, and maintenance to foster opportunities, positive development, and wellness*
   - economic enhancement of those living in poverty (e.g., work/welfare programs)
   - safety (e.g., instruction, regulations, lead abatement programs)
   - physical and mental health (incl. healthy start initiatives, immunizations, dental care, substance abuse prevention, violence prevention, health/mental health education, sex education and family planning, recreation, social services to access basic living resources, and so forth)
2. *Preschool-age support and assistance to enhance health and psychosocial development*
   - systems' enhancement through multidisciplinary team work, consultation, and staff development
   - education and social support for parents of preschoolers
   - quality day care
   - quality early education
   - appropriate screening and amelioration of physical and mental health and psychosocial problems

Early-after-onset intervention

3. *Early-schooling targeted interventions*
   - orientations, welcoming and transition support into school and community life for students and their families (especially immigrants)
   - support and guidance to ameliorate school adjustment problems
   - personalized instruction in the primary grades
   - additional support to address specific learning problems
   - parent involvement in problem solving
   - comprehensive and accessible psychosocial and physical and mental health programs (incl. a focus on community and home violence and other problems identified through community needs assessment)
4. *Improvement and augmentation of ongoing regular support*
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - preparation and support for school and life transitions
   - teaching "basics" of support and remediation to regular teachers (incl. use of available resource personnel, peer and volunteer support)
   - parent involvement in problem solving
   - resource support for parents-in-need (incl. assistance in finding work, legal aid, ESL and citizenship classes, and so forth)
   - comprehensive and accessible psychosocial and physical and mental health interventions (incl. health and physical education, recreation, violence reduction programs, and so forth)
   - Academic guidance and assistance
   - Emergency and crisis prevention and response mechanisms
5. *Other interventions prior to referral for intensive, ongoing targeted treatments*
   - enhance systems through multidisciplinary team work, consultation, and staff development
   - short-term specialized interventions (including resource teacher instruction and family mobilization; programs for suicide prevention, pregnant minors, substance abusers, gang members, and other potential dropouts)

Treatment for severe/chronic problems

6. *Intensive treatments*
   - referral, triage, placement guidance and assistance, case management, and resource coordination
   - family preservation programs and services
   - special education and rehabilitation
   - dropout recovery and follow-up support
   - services for severe-chronic psychosocial/mental/physical health problems

Meeting the Needs of All Students

Providing a

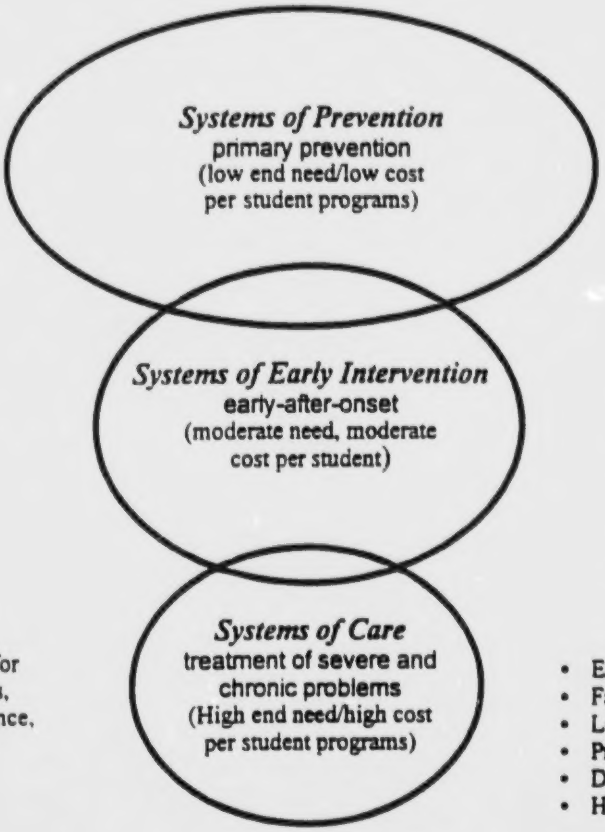
CONTINUUM OF SCHOOL AND COMMUNITY PROGRAMS & SERVICES

Ensuring use of the

LEAST INTERVENTION NEEDED

School **Resources**
(facilities, stakeholders, programs, services)

Community **Resources**
(facilities, stakeholders, programs, services)



School Resources Examples:

- General health education
- Drug and alcohol education
- Support for transitions
- Conflict resolution
- Parent involvement

Systems of Prevention
primary prevention
(low end need/low cost per student programs)

Community Resources Examples:

- Public health & safety programs
- Prenatal care
- Immunizations
- Recreation & enrichment
- Child abuse education

School Resources:

- Pregnancy prevention
- Violence prevention
- Dropout prevention
- Learning/behavior accommodations
- Work programs

Systems of Early Intervention
early-after-onset
(moderate need, moderate cost per student)

Community Resources:

- Early identification to treat health problems
- Monitoring health problems
- Short-term counseling
- Foster placement/group homes
- Family support
- Shelter, food, clothing
- Job programs

School Resources:

- Special education for learning disabilities, emotional disturbance, and other health impairments

Systems of Care
treatment of severe and chronic problems
(High end need/high cost per student programs)

Community Resources:

- Emergency/crisis treatment
- Family preservation
- Long-term therapy
- Probation/incarceration
- Disabilities programs
- Hospitalization

Systemic collaboration* is essential to establish interprogram connections on a daily basis and over time to ensure seamless intervention within each system and among *systems* of *prevention, systems* of *early intervention*, and *systems of care*.

*Such collaboration involves horizontal and vertical restructuring of programs and services
(a) between jurisdictions, school and community agencies, public and private sectors; among schools; among community agencies;
(b) with jurisdictions, school districts, and community agencies (e.g., among departments, divisions, units, schools, clusters or schools)

B. Accommodations to Reduce Problems

*I*t is easy to fall into the trap of thinking that corrective interventions for problems always should be directed at a specific individual. Adopting an interactional view, however, points to an expanded set of options regarding who or what should be the object of change (see Figure).

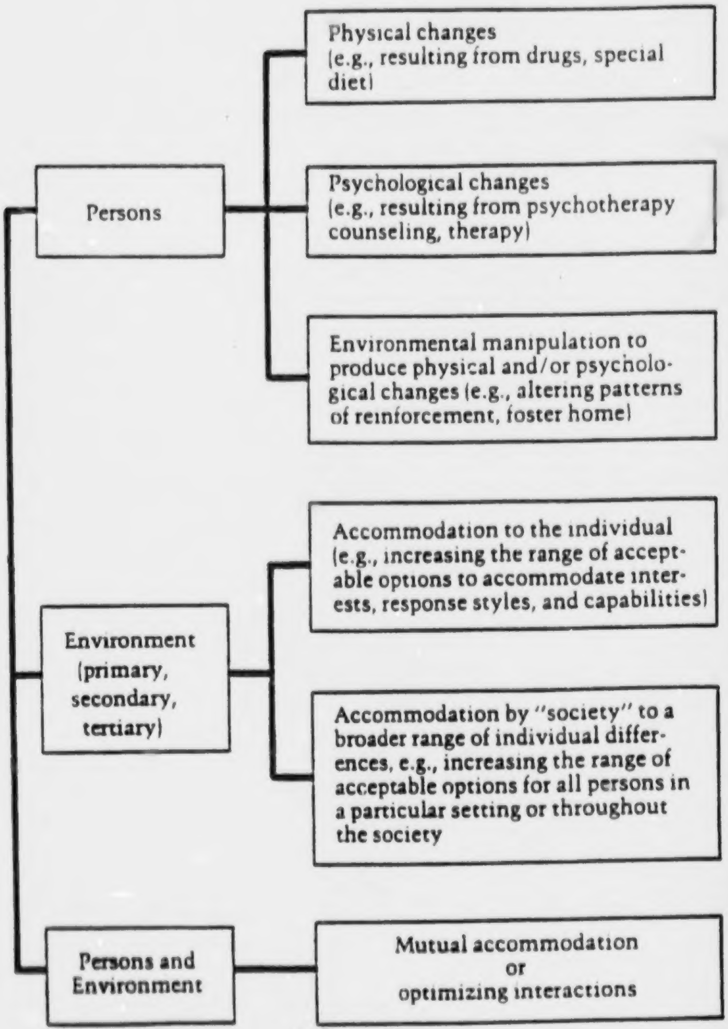
Currently, when a person is identified as having problems, efforts are made, directly or indirectly, to produce changes in the individual. Direct efforts include remediation, psychotherapy, and medically-related approaches. Indirect efforts include changing the way parents and teachers interact with youngsters.

Interventions designed to change the individual may be the most appropriate choice in any given case. Sometimes, however, the environment needs to change in ways that attempt to accommodate rather than modify individual differences. Such environmental changes are not the same as modifying the environment as an indirect way of changing the individual.

Instructing parents and teachers to be more discriminating in their use of reinforcement contingencies is meant to be an indirect way of changing the child. It is not a strategy for teaching parents and teachers the value of offering additional options whenever appro-priate and feasible -- such as increasing the range of choices about what a child is allowed to do and how the child is allowed to pursue a chosen option. It also is not the same as helping them and others in the society to understand the impact of appropriately changing their expectations about what is acceptable behavior, performance, and progress.

The implications of an expanded focal point for intervention are immense. For one, environments and the interactions between persons and environments become primary concerns for assessment activity and corrective interventions. Problem prevention efforts expand to include programs that encourage accommodation of a wider range of individual differences in schools and society. And the broadened perspective works against presumptions about dysfunctions within people as the source of most problems.

Options Related to Focal Point of Intervention
(Who or what is to be the object of change?)


Persons
Physical changes (e.g., resulting from drugs, special diet)
Psychological changes (e.g., resulting from psychotherapy counseling, therapy)
Environmental manipulation to produce physical and/or psychological changes (e.g., altering patterns of reinforcement, foster home)
Environment (primary, secondary, tertiary)
Accommodation to the individual (e.g., increasing the range of acceptable options to accommodate interests, response styles, and capabilities)
Accommodation by "society" to a broader range of individual differences, e.g., increasing the range of acceptable options for all persons in a particular setting or throughout the society
Persons and Environment
Mutual accommodation or optimizing interactions

Accommodations for Individuals with Disabilities is More than a Good Idea—it's the Law

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From an article by Michael Perla, Ed. S., NCSP, Cobb County (GA) Public Schools

Section 504

An Introduction for Parents

Background

Section 504 is part of the Rehabilitation Act of 1973, and applies to all institutions receiving federal financial assistance, such as public schools. The law essentially places an obligation on public schools to provide a "free appropriate public education" to children with disabilities, along with related services such as transportation and counseling. The main purpose of 504 is to prohibit discrimination while assuring that disabled students have educational opportunities and benefits equal to those provided to non-disabled students. The Office of Civil Rights (OCR) monitors compliance under 504. Unlike special education laws, Section 504 does not provide financial support to schools.

A student is considered to be handicapped under 504 if he or she (1) has a physical or mental impairment that substantially limits one or more major life activities, or (2) has a record of such an impairment, or (3) is regarded as having such an impairment. Limiting a major life activity is an important part of this definition and includes handicaps that limit taking care of oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing or learning. The last example, learning, is the one frequently considered in 504 cases in the schools. Section 504 requires school districts to offer services to some children who might not qualify for special education benefits under the Individuals with Disabilities Education Act of 1990 (IDEA; this federal act funds special education services). For example, children who have AIDS, asthma and diabetes may all be covered under Section 504.

Eligibility/Assessment/Accommodations Under 504

Schools must notify parents of their rights regarding identification, evaluation and placement of children with suspected handicaps prior to starting a Section 504 evaluation. In addition, students who are not found eligible under IDEA should be considered for possible eligibility under Section 504. In a 504 referral, the school often tries to determine: (1) Does the student have a physical or mental impairment? (2) Does the impairment affect one of the major life activities? If the answers to these questions are yes, the student may be entitled to a Section 504 accommodation plan. Accommodations must be based on a child's educational needs and may include curricular, classroom, school and grading modifications.

Section 504 requires school districts to develop detailed procedures for identifying and serving children with disabilities. Like other special education laws, 504 requires schools to conduct activities that will help locate and identify children who have disabilities and are not currently receiving needed special services.

Parental Rights and Procedures Under 504

Referral: Parents, guardians or school personnel may refer students suspected of having a handicap to the Section 504 coordinator or similar personnel. Potential candidates for 504 services include children with cancer, communicable diseases, medical conditions and Attention Deficit Hyperactivity Disorder...

Services under 504: If a child is found eligible under 504, services are primarily provided in the regular education classroom. The types of services offered might include the use of behavioral management techniques (e.g., a token economy), adjusting class schedules, mollifying tests and tailoring homework assignments.

Home-school collaboration: Parents can help increase the likelihood that 504 plans are effective by working closely with general educators and other school personnel to implement intervention programs both at school and at home. Regular parent-teacher conferences are likely to help foster this relationship.

Resources for Parents

Rothstein, L.F. (1995). *Special education law (2nd ed.).* New York: Longman Publishers.

Zirkel, P.A. (1993). *Section 504 and the schools.* Horsham. PA: LRP Publications

Ideas into Practice

Asking for Accommodations

Primary health care providers, parents, and others who identify youngsters experiencing behavior, emotional, and learning problems need to know about Section 504 of the 1973 Rehabilitation Act.

Section 504 is anti-discrimination, civil rights legislation (not a grant program). It provides a basis to seek accommodations at school not only for students who are eligible under the Individuals wit Disabilities Education Act (IDEA) but for any who are identified as having some physical or mental impairment that affects a major life activity, such as learning at school. Accommodations to meet educational needs may focus on the curriculum, classroom and homework assignments, testing, grading, and so forth. Such accommodations are primarily offered in regular classrooms.

Below is a fact sheet developed by folks in New Mexico to provide a quick overview. (Thanks to Steve Adelsheim for sharing it!)

General Purpose

Section 504 is a broad civil rights law which protects the rights of individuals with "disabilities" in programs and activities that receive federal financial assistance from the U.S. Department of Education.

Who is protected?

Section 504 protects all school-age children who qualify as disabled, i.e., (1) has or (2) has had a physical or mental impairment which substantially limits a major life activity or (3) is regarded as disabled by others. Major life activities include walking, seeing, breathing, teaming, working, caring for oneself and performing manual tasks. The disabling condition need only limit one major life activity in order for the student to be eligible. Children receiving special education services under the Individual's with Disabilities Act (IDEA) are also protected by Section 504.

Examples of potential 504 disabling conditions not typically covered under IDEA are:

- *communicable diseases
- *Tuberculosis
- *HIV/AIDS
- *medical condition (asthma, allergies, diabetes, heart disease)
- *temporary conditions due to illness or accident
- *Attention Deficit Hyperactivity Disorder
- *behavioral difficulties
- *drug/alcohol addiction (if the student is no longer using drugs/alcohol)

A 504 plan provides:

- *an evaluation based on current levels of performance, teacher reports, and documentation of areas of concern
- *the development/implementation of an accommodation plan which specifies "reasonable" modifications in order for the student to benefit from his/her educational program;
- *procedural safeguards for students and parents including written notification of all District decisions concerning the student's evaluation or educational placement and due process:
- *review and re-evaluation of modifications and placement on a regular basis and prior to any change in placement.

A 504 plan should be considered when:

- *a student shows a pattern of not benefiting from the instruction being provided
- *retention is being considered
- *a student returns to school after a serious illness or injury
- *long-tem suspension or expulsion is being considered
- *a student is evaluated and found not eligible for Special Education services or is transitioning out of Special Education
- *a student exhibits a chronic health or mental health condition
- *substance abuse is an issue
- *when a student is "at risk" for dropping out
- *when a student is taking medication at school

For more information, contact your local school administration.

Also see L. Miller & C. Newbill (1998). *Section 504 in the classroom: How to design & implement accommodation plans.* Austin, TX: pro.ed.

Broadening the Concept of Cultural Competence

Because many young people experience biases and prejudices associated with one or more "cultural differences," the *Family and Youth Services Bureau** has taken pains to define cultural diversity. An African American lesbian, for example, is tied to, and some-times torn between, communities of color, gender, and sexual orientation, and may have experienced different forms of racist, sexist, and homophobic attitudes in each. The following expanded definitions, therefore, are meant to foster appreciation of the need to develop cultural competence. Each factor, of course, must be considered in the context of individual experience.

- **Ethnic/Racial Background:** Any of the different varieties or populations of human beings distinguished by physical traits, blood types, genetic code patterns, or inherited characteristics unique to an isolated breeding population. People from different racial backgrounds have diverse perspectives, customs and social upbringing. Because of the historically dominant nature of a majority culture, most people have little exposure to different racial cultures.
- **Gender Culturalization**: Societal influences, messages, or "training" to behave in a certain ways based on one's gender. The majority culture in most parts of the world is the patriarchy, where male 'qualities' are more valued and men are provided access to greater opportunity. Thus, in very insidious ways, young girls and boys are acculturated differently, which affects their sense of self-worth and ability to fulfill their potential.
- **Socioeconomic/Educational Status:** Involving both social and economic factors and/or access to educational opportunities. A person's socioeconomic status can be a major factor in development as it relates to access to opportunity, social status, the ability to meet primary survival needs (food, clothing, shelter), and the messages received about what can be hoped for and attained. Closely related to socioeconomic status is access to educational opportunities that result in exposure to new ideas, the ability to think critically, and a willingness to consider different points of view.
- **Sexual Orientation:** A person's interest in, or innate desire to, develop emotional and physical relationships that are heterosexual, homosexual, or bisexual. The majority culture sanctions heterosexual behavior as the norm. Homosexuals and bisexuals, therefore, have been forced to keep their sexual orientation private, often out of fear, and those struggling with gender identity issues face similar isolation. Homo-phobia remains a public acceptable discrimination.
- **Physical Capacity:** The ability to function or perform tasks based on one's physical capabilities or limit-ations. The majority culture has until recently created systems and structures primarily suited for those with full physical capacity, and has devalued people with-out such capacity. Passage of the Americans with Disabilities Act now requires local organizations to modify systems and structures to provide broader access to persons with disabilities.
- **Age/Generational:** The distinct phases of human development, both innate and socialized; the beliefs/attitudes/values of persons born during the same period of time. Each generation has its own distinct culture, and values, based on the time they were born, lived as children, and transitioned to adulthood. The division between youth, adults, and the elderly has become more pronounced due to family relocations and breakdowns in intergenerational activities.
- **Personality Type:** The patterns and qualities of personal behavior as expressed by physical, emotional, or intellectual activities or responses to situations and people. People have innate personality types that affect their interaction with others. Extroverts, for example, may be more comfortable in large group settings, while introverts, who can adapt to such settings, may draw strength from their private time. While personality type is affected by age, experience, and circumstance, key personality-related preferences and styles remain with most people throughout their lifetime.
- **Spirituality/Religious Beliefs:** Of the spirit or soul as distinguished from material matters; characterized by the adherence to a religion and its tenets or doctrines. There are numerous religions, both formal and informal, that guide people's lives. Each has its own distinct traditions and belief systems. Further, while some people do not belong to an organized religion, they believe in spiritual feelings and the connectedness between people with certain values.
- **Regional Perspectives:** The words, customs, etc., particular to a specific region of a country or the world. Each corner of the world, and even the regions within a country, has traditions, rites of passage, learning experiences, and customs that are unique. Working with people requires an understanding of the special perspectives/life experiences they acquired growing up in different parts of the world.
- **New Immigrant Socialization:** The adaptation process of those recently relocated to a new environment. Relocating to a new country or region of the world requires adapting to new sights, sounds, and customs. This process is typically different for each generation of a family, with young people often adapting more quickly to the new culture. These differential adaptation patterns can affect the family unit as much as the change in culture itself.

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*Adapted from *A Guide to Enhancing the Cultural Competence of Runaway and Homeless Youth Programs* (1994). USDHHS, Admin. for Children and Families, Admin. on Children, Youth, and Families, Families & Youth Services Bureau. Washington, DC.

For more on this topic, see the Center's Introductory Packet entitled: *Cultural Concerns in Addressing Barriers to Learning.*

communities together

FACT SHEET

Cultural Competence in Serving Children and Adolescents With Mental Health Problems

All cultures practice traditions that support and value their children and prepare them for living in their society. This way, cultures are preserved for future generations.

Culturally competent mental health service providers and the agencies that employ them are specially trained in specific behaviors, attitudes, and policies that recognize, respect, and value the uniqueness of individuals and groups whose cultures are different from those associated with mainstream America. These populations are frequently identified as being made up of people of color—such as Americans of African, Hispanic, Asian, and Native American descent. Nevertheless, cultural competence as a service delivery approach can be applied to systems that serve all persons, because everyone in the society has a culture and is part of several subcultures, including those related to gender, age, income level, geographic region, neighborhood, sexual orientation, religion, and physical disability.

Culturally competent service providers are aware and respectful of the importance of the values, beliefs, traditions, customs, and parenting styles of the people they serve. They are also aware of the impact of their own culture on the therapeutic relationship and take all of these factors into account when planning and delivering services for children and adolescents with mental health problems and their families.

In a "System of Care," local organizations work in teams–with families as critical partners–to provide a full range of services to children and adolescents with serious emotional disturbances. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should also address and respect the culture and ethnicity of the people they serve. (For more information on systems of care, call 1.800.789.2647.)

Goals and Principles of Cultural Competence

Culturally competent "systems of care" provide appropriate services to children and families of all cultures. Designed to respect the uniqueness of cultural influences, these systems work best within a family's cultural framework. Nine principles govern the development of culturally competent programs:

1. The family, however defined, is the consumer and usually the focus of treatment and services.
2. Americans with diverse racial/ethnic backgrounds are often bicultural or multicultural. As a result, they may have a unique set of mental health issues that must be recognized and addressed.
3. Families make choices based on their cultural backgrounds. Service providers must respect and build upon their own cultural knowledge as well as the families' strengths.
4. Cross-cultural relationships between providers and consumers may include major differences in world views. These differences must be acknowledged and addressed.

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration • Center for Mental Health Services
5600 Fishers Lane, Room 13-103 • Rockville, Maryland 20857 • Telephone 301.443.2792

CARING FOR EVERY CHILD'S MENTAL HEALTH: Communities Together

For information about children's mental health, contact the CMHS Knowledge Exchange Network
PO Box 42490 • Washington, DC 20015 • Toll-free 1800.789.2647 • FAX 301.984.8796
TTY 301.443.9006 • CMHS Electronic Bulletin Board 1800.790.2647

SAMH

5. Cultural knowledge and sensitivity must be incorporated into program policymaking, administration, and services.
6. Natural helping networks such as neighborhood organizations, community leaders, and natural healers can be a vital source of support to consumers. These support systems should be respected and, when appropriate, included in the treatment plan.
7. In culturally competent systems of care, the community, as well as the family, determine direction and goals.
8. Programs must do more than offer equal, nondiscriminatory services; they must tailor services to their consumer populations.
9. When boards and programs include staff who share the cultural background of their consumers, the programs tend to be more effective.

Ideally, culturally competent programs include multilingual, multicultural staff and involve community outreach. Types of services should be culturally appropriate; for example, extended family members may be involved in service approaches, when appropriate. Programs may display culturally relevant artwork and magazines to show respect and increase consumer comfort with services. Office hours should not conflict with holidays or work schedules of the consumers.

Developing Cultural Competence

Although some service providers are making progress toward cultural competence, much more needs to be done. Increased opportunities must be provided for ongoing staff development and for employing multicultural staffs. Improved culturally valid assessment tools are needed. More research will be useful in determining the effectiveness of programs that serve children and families from a variety of cultural backgrounds.

For many programs, cultural competence represents a new way of thinking about the philosophy, content, and delivery of mental health services. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice. Even the concept of a mental disorder may reflect a western culture medical model.

At the Policymaking Level

Programs that are culturally competent:

- appoint board members from the community so that voices from all groups of people within the community participate in decisions;
- actively recruit multiethnic and multiracial staff;
- provide ongoing staff training and support developing cultural competence;
- develop, mandate, and promote standards for culturally competent services;
- insist on evidence of cultural competence when contracting for services;
- nurture and support new community-based multicultural programs and engage in or support research on cultural competence;
- support the inclusion of cultural competence on provider licensure and certification examinations; and
- support the development of culturally appropriate assessment instruments, for psychological tests, and interview guides.

At the Administrative Level

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Culturally competent administrators:

- include cultural competency requirements in staff job descriptions and discuss the importance of cultural awareness and competency with potential employees;
- ensure that all staff participate in regular, inservice cultural competency training;
- promote programs that respect and incorporate cultural differences; and
- consider whether the facility's location, hours, and staffing are accessible and whether its physical appearance is respectful of different cultural groups.

At the Service Level

Practitioners who are culturally competent:

- learn as much as they can about an individual's or family's culture, while recognizing the influence of their own background on their responses to cultural differences;
- include neighborhood and community outreach efforts and involve community cultural leaders if possible;
- work within each person's family structure, which may include grandparents, other relatives, and friends;
- recognize, accept, and, when appropriate, incorporate the role of natural helpers (such as shamans or curanderos);
- understand the different expectations people may have about the way services are offered (for example, sharing a meal may be an essential feature of home-based mental health services; a period of social conversation may be necessary before each contact with a person; or access to a family may be gained only through an elder);
- know that, for many people, additional tangible services—such as assistance in obtaining housing, clothing, and transportation or resolving a problem with a child's school—are expected, and work with other community agencies to make sure these services are provided;
- adhere to traditions relating to gender and age that may play a part in certain cultures (for example, in many racial and ethnic groups, elders are highly respected). With an awareness of how different groups show respect, providers can properly interpret the various ways people communicate.

Achieving Cultural Competence

To become culturally competent, programs may need to:

- assess their current level of cultural competence;
- develop support for change throughout the organization and community;
- identify the leadership and resources needed to change;
- devise a comprehensive cultural competence plan with specific action steps and deadlines for achievement; and
- commit to an ongoing evaluation of progress and a willingness to respond to change.

Important Messages About Children's and Adolescents' Mental Health:

- Every child's mental health is important.
- Many children have mental health problems.
- These problems are real and painful and can be severe.
- Mental health problems can be recognized and treated.
- Caring families and communities working together can help.
- Information is available; call 1.800.789.2647.

This fact sheet is based on a monograph, *Towards a Culturally Competent System of Care*, authored by Terry L. Cross, Karl W. Dennis, Mareasa R. Isaacs, and Barbara J. Bazron, under the auspices of the National Technical Assistance Center for Children's Mental Health at Georgetown University in Washington, D.C., and funded by the National Institute of Mental Health (1989).

For free information about children's and adolescents' mental health—including publications, references, and referrals to local and national resources and organizations—call 1.800.789.2647; TTY 301.443.9006.

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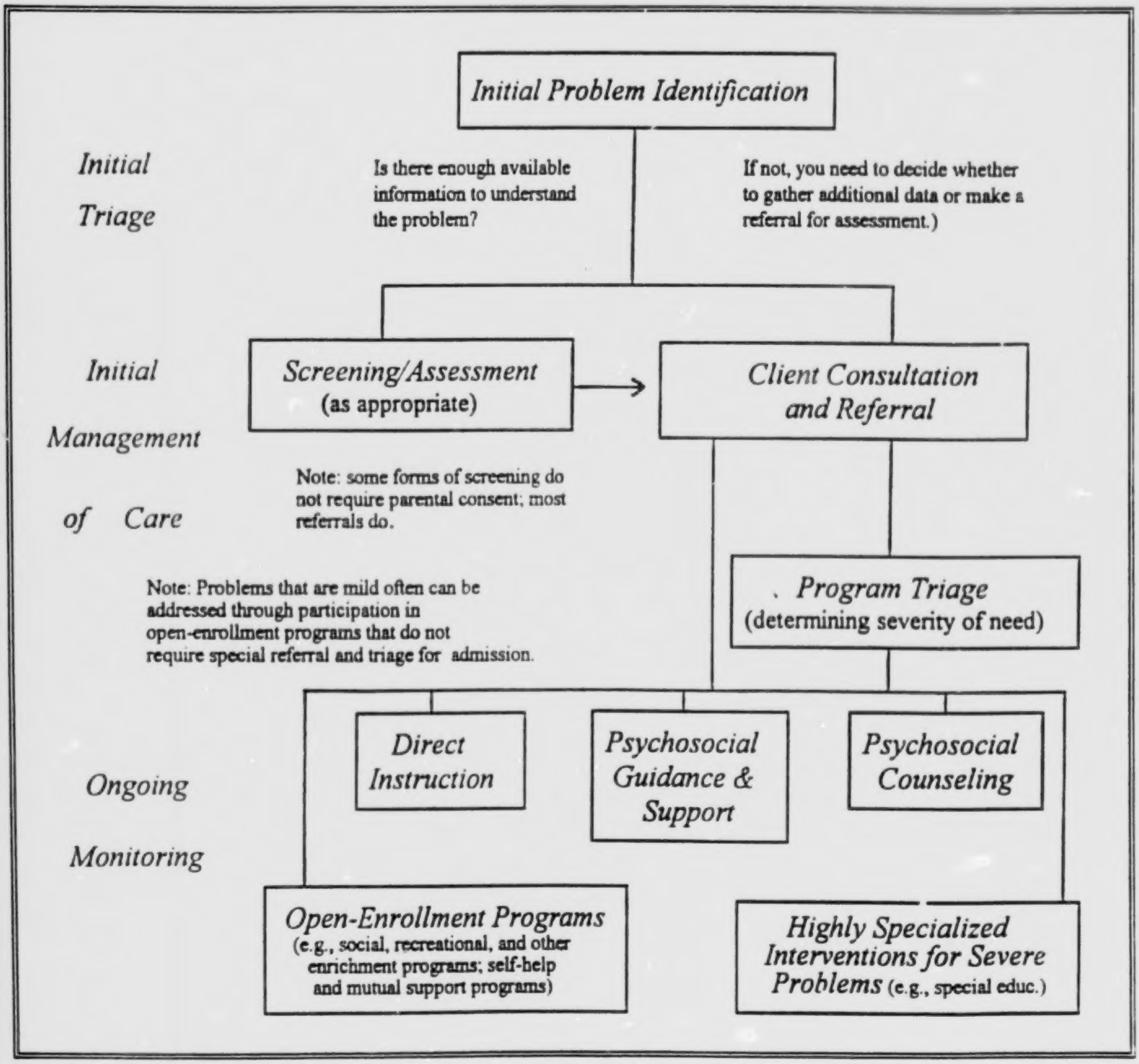
C. Developing Systems at a School for Problem Identification, Triage, Referral and Management of Care

In responding to the mental health and psychosocial concerns of students, school staff make a variety of decisions. This figure and the outline on the following page highlight matters to be considered as a school develops its systems for problem identification, triage, referral and management of care.


Initial Problem Identification
Initial Triage
Is there enough available information to understand the problem?
If not, you need to decide whether to gather additional data or make a referral for assessment.)
Initial Management of Care
Screening/Assessment (as appropriate)
Client Consultation and Referral
Note: some forms of screening do not require parental consent; most referrals do.
Note: Problems that are mild often can be addressed through participation in open-enrollment programs that do not require special referral and triage for admission.
Program Triage (determining severity of need)
Ongoing Monitoring
Direct Instruction
Psychosocial Guidance & Support
Psychosocial Counseling
Open-Enrollment Programs (e.g., social, recreational, and other enrichment programs; self-help and mutual support programs)
Highly Specialized Interventions for Severe Problems (e.g., special educ.)

The following outline highlights matters to be considered as a school develops its systems for problem identification, triage, referral, and management of care.

Problem identification

(a) Problems may be identified by anyone (staff, parent, student).
(b) There should be an Identification Form that anyone can access and fill out.
(c) There must be an easily accessible place for people to turn in forms.
(d) All stakeholders must be informed regarding the availability of forms, where to turn them in, and what will happen after they do so.

Triage processing

(a) Each day the submitted forms must be reviewed, sorted, and directed to appropriate resources by a designated and trained triage processor. Several individuals can share this task; for example, different persons can do it on a specific day or for specified weeks.
(b) After the sorting is done, the triage processor should send a Status Information Form to the person who identified the problem (assuming it was not a self-referral).

Clients directed to resources or for further problem analysis and recommendations

(a) For basic necessities of daily living (e.g., food, clothing, etc.), the triage processor should provide information about resources either through the person who identified the problem or directly to the student/family in need.
(b) If the problem requires a few sessions of immediate counseling to help a student/ family through a crisis, the triage processor should send the form to the person who makes assignments to on-site counselors.
(c) The forms for all others are directed to a small triage "team" (1-3 trained professionals) for further analysis and recommendations. (If there is a large case load, several teams might be put into operation.) Members of such a team may not have to meet on all cases; some could be reviewed independently with recommendations made and passed on the next reviewer for validation. In complex situations, however, not only might a team meeting be indicated, it may be necessary to gather more information from involved parties (e.g., teacher, parent, student).

Interventions to ensure recommendations and referrals are pursued appropriately

(a) In many instances, peripheral interventions should be recommended. This means a site must be equipped to implement and monitor the impact of such recommendations.
(b) When students/families are referred for health and social services, procedures should be established to facilitate motivation and ability for follow-through. Care management should be designed to determine follow-through, coordination, impact, and possible need for additional referrals.
(c) Referrals to assess the need for special or compensatory education often are delayed because of a waiting list. Back logs should be monitored and arrangements made to catch-up (e.g., by organizing enough released time to do the assessments and reviews).

Management of care (case monitoring and management)

(a) Some situations require only a limited form of monitoring (e.g., to ensure follow-through). A system must be developed for assigning care monitors as needed. Aides and paraprofessionals often can be trained to for this function.
(b) Other situations require intensive management by specially trained professionals to (1) ensure interventions are coordinated/integrated and appropriate, (2) continue problem analysis and determine whether appropriate progress is made, (3) determine whether additional assistance is needed, and so forth. There are many models for intensive management of care. For example, one common approach is to assign the responsibility to the professional who has the greatest involvement (or best relationship) with the student/family.
(c) One key and often neglected function of the care manager is to provide appropriate status updates to all parties who should be kept informed.

This material is from the Center's Technical Aid Packet entitled *School-based Client Consultation, Referral, and Management of Care* which discusses the importance of approaching student clients as consumers and to think in terms of managing *care* not *cases*. The packet also discusses pereferral interventions and deals with referral as a multifaceted intervention. Examples of tools to aid in these processes are included. See Section V for information on how to request this technical resource aid.

D. Treatments for Psychosocial Problems and Disorders

A continuum of interventions for addressing psychosocial problems was presented at the beginning of section II. It is easy to conceptualize a comprehensive set of interventions. It is excruciatingly hard to (1) establish such a range of programs, (2) integrate those that are in operation, and (3) conduct the type of research that advances understanding.

Given the difficulty in establishing comprehensive, integrated programmatic efforts, it is not surprising that research on this topic is almost nonexistent. Physical and mental health programs, for example, rarely are coordinated with each other or with social service, educational, and vocational programs, and thus illustrate the problem of piecemeal and fragmented intervention.

For the most part, programs for each type of problem are developed and function separately. An individual identified as having several problems may be involved in counseling with several professionals working independently of each other.

Deficiencies related to comprehensiveness and interface are attributable in significant measure to the way interventions are conceived and organized and the way professionals understand their roles and functions. Most practitioners and intervention researchers spend the majority of their time working directly with specific interventions and samples and give little thought or time to comprehensive models of mechanisms for program development and collaboration.

There is agreement in making general decisions about intervening for problems that activity should be kept to the necessary minimum. For example, if an individual with emotional problems can be helped effectively at a community agency, this seems better than placing the person in a mental hospital. For special education populations, when a student with learning or behavior problems can be worked with effectively in a regular classroom, placement in a special education program is inappropriate. There is strong disagreement, however, in treatment orientations. Should one focus on underlying factors, on observable behaviors, or both?

The *underlying factors* orientation is based on the assumption that many problems in functioning are symptoms of an underlying problem. As outlined in the Table, practitioners adopting this orientation hypothesize and attempt to address motivational and developmental differences. The roots of the orientation are found in medical, psycho-therapeutic, and educational concepts. For instance, emotional distress is identified as underlying a behavior problem. In turn, the emotional distress is seen as psychologically based.

Corrective interventions emerging from the underlying factors orientation usually are built on assessments designed to analyze areas such as perceptual, motor, cognitive, language, social, and emotional functioning. In addition, psychoneurological or neurological testing may be done to aid diagnosis. Intervention strategies draw on psycho-therapeutic principles. Examples are application of broad-based psychodynamic principles, use of social interaction and modeling, rapport building to reduce anxiety and increase positive involvement, and so forth. When underlying factors appear resistant to treatment, interveners teach individuals ways to compensate for their problems. And although the primary overall concern is with underlying factors, intervention rationales may also designate provision of support for ongoing growth and learning.

In contrast, interveners adopting an *observable factors orientation* see no value in assumptions about underlying factors. Instead, individuals with problems are seen as not yet having learned necessary skills or as having acquired interfering behaviors.

The conceptual roots of the observable factors orientation are in behaviorism (operant and cognitive behavior modification). Proponents of this approach assess knowledge and skills directly associated with daily life tasks. Performance below prevailing standards for an individual's level of development is seen as indicating missing capabilities. Behavioral objectives are formulated to teach these missing capabilities and to address any interfering behaviors. Direct intervention approaches are stressed, such as eliciting and reinforcing specific responses and instruction in cognitive self-direction and monitoring. That is, corrective strategies emphasize direct and system-atic teaching and behavior management drawing on behavior change principles.

Because neither orientation is sufficiently effective over the long run, proponents in each camp have looked to contemporary cognitive concepts and methods in evolving their approaches. Essentially, they have incorporated instruction of efficient strategies for planning, self-direction, remembering, self-monitoring, problem solving, and so forth. Currently, *metacognitive strategies* are widely used in both camps. Proponents of the two prevailing orientations adapt such strategies to fit in with their own views. That is, those with an underlying factors orientation view metacognitive strategies as an underlying ability or as a way for an individual to compensate for an area of dysfunction. Advocates of observable factors see metacognitive strategies as another set of skills clients should acquire through direct instruction.

Treatment and remedial approaches in psychology and education have been described extensively in books and journals. One reads about counseling, behavior modification, psychodynamic therapy, remedial techniques, rehabilitation, metacognitive strategies, and so forth.

Table: Contrasting Orientations to Treatment and Remediation

	UNDERLYING FACTORS ORIENTATION	**OBSERVABLE FACTORS ORIENTATION**
PRIMARY OVERALL CONCERN	Motivational and developmental differences and disabilities that disrupt desired functioning	Unlearned skills and interfering behavior
	Specific Areas of Concern	**Specific Areas of Concern**
	Motivation • reactive motivation problems • proactive motivation problems ***Development*** • perceptual problems • motor problems • cognitive problems • language problems • social problems • emotional problems *Knowledge, skills, and attitudes to compensate for disabilities*	Knowledge and skills relevant for performing life tasks • readiness needs Contemporary task needs • general life adjustment needs
SECONDARY CONCERNS	Enhancing intrinsic motivation knowledge and skills relevant for performing life tasks	Interfering behaviors (e g. poor impulse control, lack of sustained attention)
TERTIARY CONCERNS	Interfering behaviors	
PROCESS COMPONENTS	**Assessment**	**Assessment**
	Construct-oriented assessment of developmental and motivational functioning as a basis for program planning and evaluation	Task-based assessment of knowledge and sequential skills as a basis for program planning and evaluation
	Form of Objectives	**Form of Objectives**
	Nonbehavioral, as well as behavioral and criterion-referenced objectives	Behavioral and criterion-referenced objectives
	Treatment/Remedial Rationale and Methods	**Treatment/Remedial Rationale and Methods**
	Therapeutic-oriented interventions (primary emphasis on establishing rapport through interpersonal dynamics and use of a variety of intervention models) • counseling and psychotherapy • expanded life task options and choices • minimized coercion • enhanced interpersonal option • accommodation of a wide range of motivational and developmental differences • exercises intended to correct developmental anomalies and accelerate lagging development • eclectic instruction related to compensatory strategies • eclectic strategies for reducing interfering behaviors	Behavior change interventions (primary emphasis on establishing control over behavior through manipulation of reinforcers and use of cognitive self-direction and monitoring) • direct instruction to teach missing skills and information • behavior management to reduce interfering behaviors

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Addressing Barriers to Learning

New ways to think . . .
Better ways to link

Volume 6, Number 1
Winter, 2001

There is no way to avoid the fact that better achievement and student well-being requires more than good instruction and well-managed classrooms and schools.

Mechanisms for Delivering MH in Schools

What does the term
mental health in schools mean?

Ask five people and you'll
probably get five different answers.

To establish greater clarity, the *Policy Leadership Cadre for Mental Health in Schools* is working on a document outlining guidelines, describing delivery mechanisms, and much more. A working draft of the document currently is circulating to elicit feedback; the following excerpts are included here as part of the process.*

Analyses of initiatives across the country suggest *five* delivery mechanisms are used to provide mental health programs/services in schools (see Exhibit on page 2). The mechanisms vary in format and differ in focus and comprehensiveness, but they are not necessarily mutually exclusive.

The focus may be primarily on treatment of MH and psychosocial problems, on prevention of such problems, or on promoting positive mental health (e.g., healthy social and emotional development). In terms of comprehensiveness, the emphasis may be mainly on providing and/or referring for clinical treatment. Or the intent may be to develop a full continuum of programs and services to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment.

What follows is a brief discussion to clarify the major delivery mechanisms outlined on page 2.

School-Financed Student Support Services

Most school districts employ student support or "pupil services professionals," such as school psychologists, counselors, and social workers. These personnel perform services connected with MH and psychosocial problems (including related services designated for special education students). The format usually is a combination of centrally-based and school-based services.

Federal and state mandates and special projects tend to determine how many pupil services professionals are employed by a district. Governance of their daily practices commonly is centralized at the school district level. In addition to school psychologists, counselors, and social workers, other personnel such as school nurses and special education staff (e.g., resource teachers, specialists for rehabilitation and occupational therapy) play a role in addressing mental health and psychosocial problems. Moreover, these professionals often extend their impact through supervision of aids, paraprofessional, and volunteers working in schools (e.g., classrooms, playgrounds, office, after-school and enrichment programs).

Any of these personnel may be engaged in a wide array of MH related activity, including promotion of social and emotional development, direct services and referrals, outreach to families, and various forms of support for teachers and other school personnel. The focus may be on (1) prevention and prereferral interventions for mild problems, (2) programs aimed at reducing high frequency psychosocial problems,

Contents

- *Need resources? technical assistance?* See page 3.
- Improving How Schools Address Barriers to Learning
- Page 10: Talking *with* Kids
- On page 11: Support for Transitions: Articulation Programs
- Page 12: Report on Hawai'i's CSSS

Delivery Mechanisms and Formats

The five mechanisms and related formats are:

I. ***School-Financed Student Support Services*** – Most school districts employ support service or "pupil services professionals," such as school psychologists, counselors, and social workers. These personnel perform services connected with mental health and psychosocial problems (including related services designated for special education students). The format for this delivery mechanism usually is a combination of centrally-based and school-based services.

II. ***School-District MH Unit*** – A few districts operate specific mental health units that encompass clinic facilities, as well as providing services and consultation to schools. Some others have started financing their own School-Based Health Centers with mental health services as a major element. The format for this mechanism tends to be centralized clinics with the capability for outreach to schools.

III. ***Formal Connections with Community MH Services*** – Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care (e.g., "wrap-around" services for those in special education). Four formats have emerged:

- co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers partly financed by community health organizations
- formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center
- formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of MH services
- contracting with community providers to provide needed student services

IV. ***Classroom-Based Curriculum and Special "Pull Out" Interventions*** – Most schools include in some facet of their curriculum a focus on enhancing social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:

- integrated instruction as part of the regular classroom content and processes
- specific curriculum or special intervention implemented by personnel specially trained to carry out the processes
- curriculum approach is part of a multifaceted set of interventions designed to enhance positive development and prevent problems

V. ***Comprehensive, Multifaceted, and Integrated Approaches*** – A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

- mechanisms to coordinate and integrate school and community services
- initiatives to restructure support programs and services and integrate them into school reform agendas
- community schools

and (3) strategies to meet the needs of severe and pervasive mental health problems.

While there is considerable day-to-day pressure for each school professional to work alone on a case-load, schools have increasingly created infrastructures to promote collaboration and cooperation. The most widely used is a case-focused team. This problem solving approach brings together support staff, teachers, and often family members and the student to discuss the student's problems and strengths, review effectiveness of past interventions, rethink strategies and feasible accommodations, and identify next steps. If problems are severe and pervasive, support staff may be involved in more formal assessment to see if a student qualifies for special education programs and/or other referrals. If special education is considered, an Individual Educational Program (IEP) team then determines whether the student meets criteria, and if the decision is yes, they work together with families to construct the specific plan. When related services, such as counseling are part of the IEP, these often are provided by support staff.

Most school districts distribute their pupil service personnel according to an established formula that results in assignment of an individual on a part time basis to multiple schools. Some schools supplement these allotments by using their budget allocation related to Title I or funds acquired through special project grants that allow for hiring additional support staff. Under this type of format, support personnel tend to pursue traditional roles and functions associated with their field of specialization and the mandates delineated in the categorical funding that provides their salaries. The result is piecemeal and fragmented activity that has not had a sufficient impact on the major problems students and schools are experiencing.

Some places have experimented with alternative ways to allocate student support service resources. For example, the *Denver Public Schools* designed a process whereby District coordinators inform each school of the total amount of support service time/salary they can have. A menu of options describes "non-traditional use of Specialized Services staff." This involves detailing skills that could be carried out by any support staff member (e.g., nurses, social workers, psychologists) and the skills that are unique to each profession (either due to mandate or specialized training). Schools and clusters of schools then decide on the best combination of support staff based on the needs of their building or community. In the first year of the new process, 24 schools opted to combine services that traditionally had been the responsibility of one professional and thus were able to have one support staff in their building for a greater amount of time.

School-District Mental Health Unit

The organization of mental health personnel in most school districts tends to be by profession (e.g., school psychology unit, counseling unit). In a few districts, a multidisciplinary unit operates from centralized locations and provides intensive interventions for students and families to address a range of MH and psychosocial concerns. This is particularly the case where organized school MH units are in operation. In such units and centers, there may be social workers, school psychologists, psychiatric nurses, psychiatrists, and clinical psychologists. The format for this delivery mechanism tends to be centralized clinics that are able to outreach and provide school staff with direct services and consultation. Where districts are taking the lead in establishing and financing school-based health centers, the trend is for such centers to incorporate the same type of functions pursued by clinics operated by school mental health units.

One example of a school district MH unit is in the *Memphis City School District*. This unit, in operation since 1969, is designed to integrate MH services. The staff are primarily school psychologists and social workers organized into teams. The unit offers a variety of clinical and consultation services in support of school programs. There are three satellite centers housing staff who rotate through each school in the district on a regular basis. Their primary functions are to offer psychological evaluations, counseling and therapy, abused/neglected children services, alcohol and drug abuse services, school based prevention efforts, homemaker services, staff development, parent study groups, and compliance/reporting/record keeping.

Another example is in the *Los Angeles Unified School District* which has operated a School Mental Health Unit since 1945. The unit makes services available to the entire school population through school referrals to one of three clinics. Services include psychiatric and psychosocial assessments; individual, group, and family therapy; case management; crisis intervention; and program development and demonstration projects. The unit is staffed by psychiatric social workers, clinical psychologists, psychiatric nurses, and child psychiatrists. There is close collaboration with school-based support service staff, and with teachers and administrators. The clinics are a site for research to move empirically supported treatments from laboratory to clinic settings. The unit has administrative responsibility for the training and operation of all district level crisis intervention teams. Through an interagency contract, the unit has become a MediCal Certified Child Psychiatry Outpatient Clinic and a Los Angeles County Dept. of Mental Health Contract Provider.

Formal Connections with Community MH Services

Increasingly, schools have developed connections with community agencies, often as the result of the school-based health center movement, school-linked services initiatives (e.g., full service schools, family resource centers), and efforts to develop systems of care ("wrap-around" services for those in special education). Four formats have emerged:

- co-location of community agency personnel and services at schools – sometimes in the context of School-Based Health Centers financed in part by community health organizations

- formal linkages with agencies to enhance access and service coordination for students and families at the agency, at a nearby satellite clinic, or in a school-based or linked family resource center

- formal partnerships between a school district and community agencies to establish or expand school-based or linked facilities that include provision of mental health services

- contracting with community providers to offer mandated and designated student services

Exemplars of each of these approaches are included in the Policy Leadership Cadre's document.*

Whether initiated by the community or the school, this delivery mechanism is intended to increase access to MH services and, in some formats, to enhance coordination among services provided to students and their families. Some problems have arisen related to some formats. For example, the co-location approach often has produced a new form of fragmentation in which community personnel occupy space at a school but operate as a separate entity from school support programs and services. Another problem is that some policy makers have begun to view school-linked services as a less expensive way to provide mandated services, and this perspective is increasing policies for "contracting-out" services – thereby eliminating/ reducing pupil personnel positions.

Contracting-out is especially attractive to small school districts where pupil personnel are not available in sufficient numbers to meet the mandated needs. Other instances arise when district policy makers decide only to meet mandates and determine it is less expensive to contract with outside agencies. For example, while special education designated services, such as counseling, can be provided by school staff (e.g., school counselors, social workers, or psychologists), some school districts have begun to contract privately for the services. In some places, contract agency staff also link to schools as providers for the Early Periodic Screening, Diagnosis, and Treatment program. A broader example is seen in places where contract agencies provide a range of mental health services on school campuses for students designated as eligible by county mental health assessment. An unfortunate result of the way contracting-out policies have played out in some places has been to reduce the overall amount of resources available to schools for addressing mental health and psychosocial concerns.

Classroom-Based Curriculum and Special "Pull Out" Interventions

Most schools include in some facet of the curriculum ways to enhance social and emotional functioning. Specific instructional activities may be designed to promote healthy social and emotional development and/or prevent psychosocial problems such as behavior and emotional problems, school violence, and drug abuse. And, of course, special education classrooms always are supposed to have a constant focus on mental health concerns. Three formats have emerged:

- integrated instruction as part of the regular classroom content and processes
- specific curriculum or special intervention implemented by personnel trained to carry out the processes
- a curriculum approach that is part of a multi-faceted set of interventions designed to enhance positive development and prevent problems

Mental health in schools reaches into the classroom through general instructional processes and special assistance strategies. Teachers who are sensitive to the importance of promoting social and emotional development can integrate such a focus seamlessly into their daily interactions with students. This may or may not include devoting part of the day to teaching a curriculum designed to foster relevant knowledge, skills, and attitudes. In some instances, other personnel come to the classroom or take students to another site in the school to teach such a curriculum or to involve students in special interventions designed to address specific problems. Because of the limited impact on problem behavior of only pursuing a curriculum, there has been constant advocacy for weaving classroom programs into multifaceted strategies.

The type of focus that can be integrated into the classroom is seen in the core framework of social and emotional competencies delineated by the consortium funded by the W.T. Grant Foundation. This framework can be used by school staff as guidelines for promoting healthy social and emotional development throughout the school day. (See W.T. Grant Consortium on the School-Based Promotion of Social Competence [1992]. Drug and alcohol prevention curriculum. In J.D. Hawkins, et al. [Eds.]. *Communities that care.* San Francisco: Jossey-Bass.)

There are many examples of specific curriculum. For instance, *Promoting Alternative Thinking Strategies* (PATHS) is a prominently used curriculum developed by Mark Greenberg and his colleagues. It is designed to promote emotional and social competence, reduce aggression and behavior problems, and enhance the classroom educational process. It can be used by educators and counselors as a multi-year, universal prevention approach. The curriculum provides systematic, developmentally-based lessons, materials, and instructions for teaching students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem solving skills.

The *Social Competence Promotion Program* is a structured curriculum, developed by Roger Weissberg and his colleagues. It focuses on general skill training with domain-specific instruction. The curriculum has units on stress management, self-esteem, problem solving skills, substance and health information, assertiveness training, and social networks. It is designed to enhance protective factors by teaching conflict resolution and impulse control.

An example of a special intervention is the *Primary Mental Health Project's* strategy. Developed by Emory Cowen and his colleagues and operating under various names (e.g., the Primary Intervention Program, Early Mental Health Initiative), this intervention focuses on young children with school adjustment problems such as shyness, aggression, or inattentiveness. A specially trained paraprofessional takes a child out of the classroom into a specially designed "play" room and uses play techniques and reflective listening to help the youngster enhance coping skills.

An example of a curriculum approach that is part of a multifaceted set of interventions is the *Seattle Social Development Project*. This universal, multidimensional intervention was developed by J. David Hawkins and Richard Catalano and their colleagues. It is designed to increase prosocial bonds, strengthen attachment and commitment to schools, and decrease delinquency. Teachers learn to emphasize proactive classroom management, interactive teaching, and cooperative learning – allowing students to work in small, heterogeneous groups to increase their social skills and contact with prosocial peers. Sessions encourage parents to improve communication between themselves, teachers, and students; create positive home learning environments; help their children develop academic skills, and support their academic progress.

Another example of a school-wide approach is *Project ACHIEVE* developed by Howard Knoff and George Batsche. It focuses on problem-solving, social skills, anger management, effective teaching, curriculum based assessment, parent education, academics, and organizational planning, development, and evaluation.

Comprehensive, Multifaceted, and Integrated Approaches

A few school districts have begun the process of reconceptualizing their piecemeal and fragmented approaches to addressing barriers that interfere with students having an equal opportunity to succeed at school. They are starting to restructure their student support services and weave them together with community resources and integrate all this with instructional efforts that effect healthy development. The intent is to develop a full continuum of programs and services encompassing efforts to promote positive development, prevent problems, respond as early-after-onset as is feasible, and offer treatment regimens. Mental health and psychosocial concerns are a major focus of the continuum of interventions. Efforts to move toward comprehensive, multifaceted approaches are likely to be enhanced by initiatives to integrate schools more fully into systems of care and the growing movement to create community schools. Three formats are emerging:

- mechanisms to coordinate and integrate school and community services
- initiatives to restructure student support programs and services and integrate them into school reform agendas
- community schools

Around the country, a few pioneering initiatives are coming to grips with the realities involved in addressing barriers to student learning and promoting healthy development. In doing so, they are taking advantage of existing opportunities to use categorical funds flexibly and to request wavers from regulatory restrictions. They also are using specialized personnel and other resources in increasingly cross-disciplinary and collaborative ways.

By moving toward comprehensive, multifaceted, and integrated approaches, these initiatives have started to redefine their relationship to school reform movements in order to end the marginalization of education support programs and services. For example, some approaches are conceived in terms of being an essential component of school reform and are calling on policy makers to recognize them as such. Moreover, they are demonstrating the reality of this position. Exemplars have been developed that explicitly expand school reform policy and practices beyond the prevailing limited perspective on restructuring instructional and management functions. These demonstrations address barriers to student learning as a third set of primary and essential functions for enabling students to have an equal opportunity for success at school.

Systems of Care. One of the most extensive efforts to coordinate and integrate school and community services is seen in efforts to establish *Systems of Care.* In states and localities across the nation, this initiative focuses on developing systems to coordinate and integrate mental health and related services and supports designed to help a child or adolescent with serious emotional disturbances. Local public and private organizations work in teams to plan and implement a tailored set of services for each individual child's physical, emotional, social, education, and family needs. Teams include family members and advocates and may include representatives from mental health, health, education, child welfare, juvenile justice, vocational counseling, recreation, substance abuse. The range of services may include case management, community-based in-patient psychiatric care, counseling, crisis residential care, crisis outreach teams, day treatment, education/special education services, family support, health services, independent living supports, intensive family-based counseling, legal services, protection and advocacy, psychiatric consultation, recreation therapy, residential treatment, respite care, self-help support groups, therapeutic foster care, transportation, tutoring, and vocational counseling. A case manager facilitates the individualized treatment plan.

A few pioneering efforts are underway to restructure student supports and integrate them with school reform. For example:

New American Schools' Urban Learning Center Model. This is one of the comprehensive school reform designs federal legislation encourages school to adopt. It incorporates a comprehensive, multifaceted, and integrated approach to addressing barriers to learning as a third component of school reform – equal to the instructional and governance components. This third enabling component is called "Learning Supports." In addition to focusing on addressing barriers to learning, there is a strong emphasis on facilitating healthy development, positive behavior and asset-building as the best way to prevent problems. There is a major emphasis on weaving together what is available at a school, expanding these resources through integrating school/community/home resources, and enhancing access to community resources through formal linkages. A key operational infrastructure mechanism is a resource-oriented team that clarifies resources and their best use. The elements of the learning supports component at each school involve: classroom-focused enabling to ensure a potent focus on commonplace behavior, learning, and emotional problems, support for transitions, crisis assistance and prevention, home involvement in schooling, student and family assistance, and community outreach for involvement and support.

Hawai'i's Comprehensive Student Support System. This is the umbrella concept under which the state's Dept. of Education is developing a continuum of programs/services to support a school's academic, social, emotional, and physical environments so that all students learn. The system provides five levels of student support: basic support for all students, informal additional support through collaboration, services through school-level and community programs, specialized services from the Department of Education and/or other agencies, and intensive and multiple agency services. The aim is to align programs and services in a responsive manner to create a caring community. Key elements of the program include personalized classroom climate and differentiated classroom practices, prevention/early intervention, family involvement, support for transitions, community outreach and support, and specialized assistance and crisis/emergency support and follow through. This range of proactive support requires teaming, organization and accountability. To help achieve all this, a cadre of school-based and complex-level Support Service Coordinators are being trained. (See discussion on page 12.)

Los Angeles Unified School District. Several years ago, the district formulated a *Strategic Plan for Restructuring of Student Health & Human Services.* The goals were to (1) increase effectiveness, and efficiency in providing learning supports to students and their families and (2) enhance partnerships with parents, schools, and community-based efforts to improve outcomes for youth. Building on the same body of work that was used in developing the Urban Learning Center model, the plan called for a major restructuring of school-owned pupil services in order to develop a comprehensive, multifaceted, and integrated "Learning Supports" component to address barriers to learning. Key operational infrastructure mechanisms are a school-based resource team and a cluster coordinating council that focuses on clarifying resources and their best use – all of which are concerned with developing the key elements of the learning supports component at each school. To facilitate restructuring, a cadre of change agents called Organization Facilitators was developed. The plan called for these change agents to assist in establishing the infrastructure at each school and for the high school feeder pattern with the aim of enhancing resource use, as well as integrating other resources from the community.

Community Schools. As exemplified by the Children's Aid Society, Community Schools in New York City is a partnership between the Children's Aid Society, the New York City Board of Education, the school district, and community based partners. The focus is on a model that is designed to help strengthen the educational process for teachers, parents, and students in a seamless way. The approach combines teaching and learning with the delivery of an array of social, health, child and youth development services that emphasizes community and parental involvement. Current demonstrations provide on-site child and family support services – from health-care clinics and counseling to recreation, extended education, early childhood programs, job training, immigration services, parenting programs and emergency assistance.

A Few Compilations of Practices

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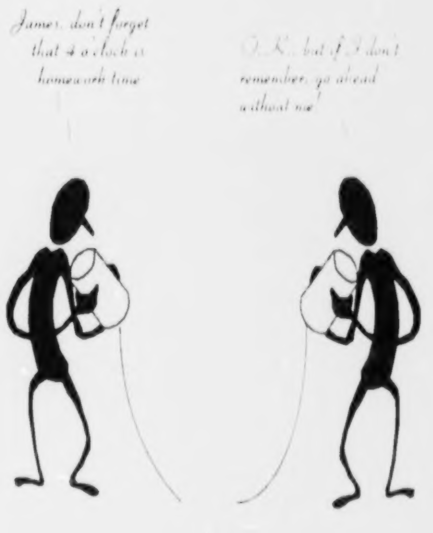
Father
(in a helpful tone):


James, don't forget that 4 o'clock is homework time
O.K., but if I don't remember, go ahead without me!

High Stakes Testing, MH, and Barriers to Learning

Those concerned about MH and addressing barriers to learning must focus on how to counteract the negative effects of high stakes testing. Of particular concern are the problems some students (and staff) are having coping with the increasing pressure to perform. In some school settings this is a significant problem for many, and schools have the responsibility to address the matter as an additional barrier to learning for those students affected.

It should be anticipated that the problems of students who will do poorly when tested will be exacerbated. Those who face retention or face the likelihood of not qualifying for graduation need more than additional academic support. Without appropriate attention to the social and emotional consequences, the long-term problem is that we are likely to lose many students and teachers. The correlation between high stakes testing and student dropout rates is worrisome: graduation tests are used in nine of the 10 states with the highest dropout rates and are not in use in the ten states with the highest graduation rates. And, with so many teachers leaving the field, we need to consider the likelihood that using high stakes testing as the primary accountability measure may be making a bad situation worse.

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Outline What Has Been Learned so Far

Use this worksheet to develop a brief outline describing the various ways that schools can provide specialized assistance for problems students and families are experiencing.

To help organize your response, think in terms of the following:

(1) What ways might the school respond when a student is not learning well or is a frequent behavior problem or often seems emotionally upset?

(2) What ways might the school help when a student/family is so poor that the student does not have adequate clothing, food, and school supplies?

Source: UCLA Center for Mental Health in Schools: Los Angeles, CA 90095-1563 (310) 824-3634;
smhp@ucla.edu.

What would you add?

Attached are sections from a self-study survey entitled:. *Student and Family Assistance Programs and Services*) For purposes of this tutorial, just read over the items. These provide a sense of what might take place to specialized assistance for students and families.

After reviewing the items, list below any additional activities you think you would want in place at your school to enhance efforts to provide specialized student and family assistance.

The survey itself can be used at a school in a number of ways (see the introductory page entitled: "About the Self-Study Process to Enhance the Component for Addressing Barriers to Student Learning").

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 824-3634; smhp@ucla.edu.

Discussion Session Exploring Outline of What Has Been Learned So Far

One of the best ways to explore what you are learning is to discuss it with others. Although this can be done informally with friends and colleagues, a regular study group can be a wonderful learning experience – if it is properly designed and facilitated.

Below are a few guidelines for study groups involved in pursuing a Training Tutorial.

(1) Put up a notice about the Training Tutorial, along with a sign up list for those who might be interested participating in a study group as they pursue the tutorial. On the sign-up list, offer several times for a meeting to organize the group.

(2) Inform interested parties about the where and when of the meeting to organize the group.

(3) Group decides on the following:

   (a) meeting time, place, number and length of sessions, amenities, etc.

   (b) how to handle session facilitation (e.g., starting and stopping on time, keeping the group task-focused and productive)

(4) All group members should commit to keeping the discussion focused as designated by the tutorial content and related activities. If the discussion stimulates other content, set up a separate opportunity to explore these matters.

Source: UCLA Center for Mental Health in Schools: Los Angeles, CA 90095-1563 (310) 824-3634; smhp@ucla.edu.

Topic 2: Understanding when specialized assistance is needed.

Reading & Activity

Readings. From: *Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders, and Perspectives for Prevention and Treatment – I. Keeping the environment in perspective as a cause of commonly identified psychosocial problems* (pp. I-1-6)

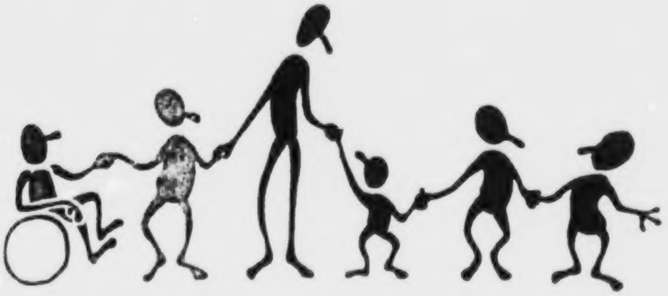
About Talking with Kids (newsletter article)

Activity. Use the various attached materials as stimuli and tools to focus application of what has been read

(1) *Outline and Discuss What Has Been Learned so Far* – How do you understand the various reasons students might have learning, behavioral, and emotional problems? (use attached worksheet)

(2) *Interviewing to Determine a Student's View of the Problem* (see attach worksheet)

(3) *Review Screening Tools* (see attached introduction to a Resource Aid Packet)



Mental Health in Schools
Center
Training and Technical Assistance

Excerpt From

GUIDEBOOK:

Common Psychosocial Problems of School Aged Youth:

Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment

This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the
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U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

CMHS
Center for Mental Health Services
SAMHSA
Substance Abuse & Mental Health Services Administration

I. Keeping The Environment in Perspective as a Cause of Commonly Identified Psychosocial Problems.

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth: The Name Game

She's depressed.

That kid's got an attention deficit hyperactivity disorder.

He's learning disabled.

What's in a name? Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders. Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

A Broad View of Human Functioning

Before the 1920's, dominant thinking saw human behavior as determined primarily by person variables, especially inborn characteristics. As behaviorism gained in influence, a strong competing view arose. Behavior was seen as shaped by environmental influences, particularly the stimuli and reinforcers one encounters.

Today, human functioning is viewed in *transactional* terms -- as the product of a reciprocal interplay between person and environment (Bandura, 1978). However, prevailing approaches to labeling and addressing human problems still create the impression that problems are determined by *either* person or environment variables. This is both unfortunate and unnecessary -- unfortunate because such a view limits progress with respect to research and practice, unnecessary because a transactional view encompasses the position that problems may be caused by person, environment, or both. This broad paradigm encourages a comprehensive perspective of cause and correction.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.*

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

E (E<--->p) E<--->P (e<--->P) P

|---|---|

Type I problems	Type II problems	Type III problems
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe andpervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

---

Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: Figure 2 presents some ideas for subgrouping Type I and III problems.

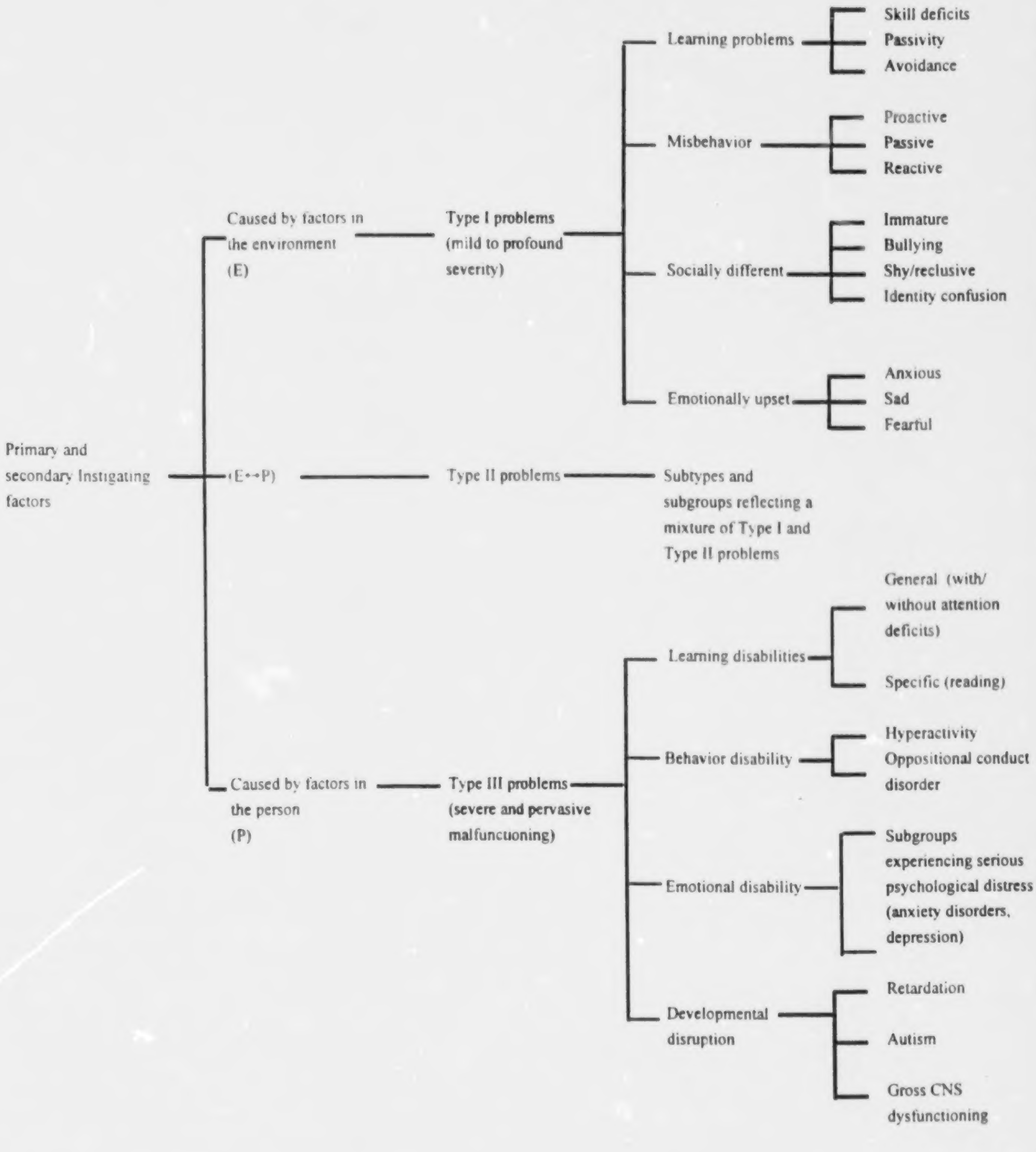
> ***There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.***
>
> *Nicholas Hobbs*

References

Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist, 33*, 344-358.

Ryan, W. (1971). *Blaming the victim.* New York: Random House.

Figure 2: Categorization of Type I, II, and III Problems


Primary and secondary Instigating factors
Caused by factors in the environment (E)
(E↔P)
Caused by factors in the person (P)
Type I problems (mild to profound severity)
Type II problems
Type III problems (severe and pervasive malfunctioning)
Learning problems
Skill deficits
Passivity
Avoidance
Misbehavior
Proactive
Passive
Reactive
Socially different
Immature
Bullying
Shy/reclusive
Identity confusion
Emotionally upset
Anxious
Sad
Fearful
Subtypes and subgroups reflecting a mixture of Type I and Type II problems
Learning disabilities
General (with/ without attention deficits)
Specific (reading)
Behavior disability
Hyperactivity
Oppositional conduct disorder
Emotional disability
Subgroups experiencing serious psychological distress (anxiety disorders, depression)
Developmental disruption
Retardation
Autism
Gross CNS dysfunctioning

Source: H. S. Adelman and L. Taylor (1993). Learning problems and learning disabilities. Pacific Grove. Brooks/Cole. Reprinted with permission.

B. Environmental Situations and Potentially Stressful Events

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

- **Challenges to Primary Support Group**
  - Challenges to Attachment Relationship
  - Death of a Parent or Other Family Member
  - Marital Discord
  - Divorce
  - Domestic Violence
  - Other Family Relationship Problems
  - Parent-Child Separation
- **Changes in Caregiving**
  - Foster Care/Adoption/Institutional Care
  - Substance-Abusing Parents
  - Physical Abuse
  - Sexual Abuse
  - Quality of Nurture Problem
  - Neglect
  - Mental Disorder of Parent
  - Physical Illness of Parent
  - Physical Illness of Sibling
  - Mental or Behavioral disorder of Sibling
- **Other Functional Change in Family**
  - Addition of Sibling
  - Change in Parental Caregiver
- **Community of Social Challenges**
  - Acculturation
  - Social Discrimination and/or Family Isolation
- **Educational Challenges**
  - Illiteracy of Parent
  - Inadequate School Facilities
  - Discord with Peers/Teachers
- **Parent or Adolescent Occupational Challenges**
  - Unemployment
  - Loss of Job
  - Adverse Effect of Work Environment
- **Housing Challenges**
  - Homelessness
  - Inadequate Housing
  - Unsafe Neighborhood
  - Dislocation
- **Economic Challenges**
  - Poverty
  - Inadequate Financial Status
- **Legal System or Crime Problems**
- **Other Environmental Situations**
  - Natural Disaster
  - Witness of Violence
- **Health-Related Situations**
  - Chronic Health Conditions
  - Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics.

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Change in crying
- Change in mood
- Sullen, withdrawn

Impulsive/Hyperactive or Inattentive Behaviors
- Increased activity

Negative/Antisocial Behaviors
- Aversive behaviors, i.e., temper tantrum, angry outburst

Feeding, Eating, Elimination Behaviors
- Change in eating
- Self-induced vomiting
- Nonspecific diarrhea, vomiting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments
- Inability to engage in or sustain play

Sexual Behaviors
- Arousal behaviors

Relationship Behaviors
- Extreme distress with separation
- Absence of distress with separation
- Indiscriminate social interactions
- Excessive clinging
- Gaze avoidance, hypervigilant gaze...

EARLY CHILDHOOD (3-5Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- N/A

Emotions and Moods
- Generally sad
- Self-destructive behaviors

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level

Negative/Antisocial Behaviors
- Tantrums
- Negativism
- Aggression
- Uncontrolled, noncompliant

Feeding, Eating, Elimination Behaviors
- Change in eating
- Fecal soiling
- Bedwetting

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Regression or delay in developmental attainments

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Ambivalence toward independence
- Socially withdrawn, isolated
- Excessive clinging
- Separation fears
- Fear of being alone

MIDDLE CHILDHOOD (6-12Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Anxiety
- Changes in mood
- Preoccupation with stressful situations
- Self -destructive
- Fear of specific situations
- Decreased self-esteem

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- High activity level
- Impulsivity

Negative/Antisocial Behaviors
- Aggression
- Noncompliant
- Negativistic

Feeding, Eating, Elimination Behaviors
- Change in eating
- Transient enuresis, encopresis

Somatic and Sleep Behaviors
- Change in sleep

Developmental Competency
- Decrease in academic performance

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- Change in social interaction such as withdrawal
- Separation fear
- Fear of being alone

Substance Use/Abuse...

ADOLESCENCE (13-21Y)

BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
- Transient physical complaints

Emotions and Moods
- Sadness
- Self-destructive
- Anxiety
- Preoccupation with stress
- Decreased self-esteem
- Change in mood

Impulsive/Hyperactive or Inattentive Behaviors
- Inattention
- Impulsivity
- High activity level

Negative/Antisocial Behaviors
- Aggression
- Antisocial behavior

Feeding, Eating, Elimination Behaviors
- Change in appetite
- Inadequate eating habits

Somatic and Sleep Behaviors
- Inadequate sleeping habits
- Oversleeping

Developmental Competency
- Decrease in academic achievement

Sexual Behaviors
- Preoccupation with sexual issues

Relationship Behaviors
- Change in school activities
- School absences
- Change in social interaction such as withdrawal

Substance Use/Abuse...

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

12

Lessons Learned About Talking *With* Kids

To help another, it is of great value and in many instances essential to know what the other is thinking and feeling. The most direct way to find this out is for the person to tell you. But, individuals probably won't tell you such things unless they think you will listen carefully. And the way to convince them of this is to listen carefully.

Of course, you won't always hear what you would like.

> Helper: *Well, Jose, how do you like school?*
> Jose: *Closed!*

In general, effective communication requires the ability to carry on a *productive dialogue*, that is, to talk with, not at, others. This begins with the ability to be an active (good) listener and to avoid prying and being judgmental. It also involves knowing when to share information and relate one's own experiences as appropriate and needed. The following are suggestions for engaging youngsters in productive dialogues.

I. Creating the Context for Dialogues

- Create a private space and a climate where the youngster can feel it is safe to talk.
- Clarify the value of keeping things confidential.
- Pursue dialogues when the time, location, and conditions are right.
- Utilize not just conferences and conversations, but interchanges when working together (e.g. exploring and sampling options for learning).

II. Establishing Credibility (as someone to whom it is worth talking)

- Respond with *empathy, warmth, and nurturance* (e.g., the ability to understand and appreciate what others are thinking and feeling, transmit a sense of liking, express appropriate reassurance and praise, minimize criticism and confrontation).
- Show *genuine regard and respect* (e.g., the ability to transmit real interest, acceptance, and validation of the other's feelings and to interact in a way that enables others to maintain a feeling of integrity and personal control.
- Use active and undistracted listening.
- Keep in mind that you want the student to *feel* more competent, self-determining, and related to you (and others) as a result of the interchange.

III. Facilitating Talk

- Avoid interruptions.
- Start slowly, avoid asking questions, and minimize pressure to talk (the emphasis should be more on conversation and less on questioning).
- Encourage the youngster to take the lead.
- Humor can open a dialogue; sarcasm usually has the opposite effect.
- Listen with interest.
- Convey the sense that you are providing an opportunity by extending an invitation to talk and avoiding the impression of another demanding situation (meeting them "where they are at" in terms of motivation and capability is critical in helping them develop positive attitudes and skills for oral communication).
- Build on a base of natural, informal inter-changes throughout the day.
- When questions are asked, the emphasis should be on open-ended rather than Yes/No questions.
- Appropriate self-disclosure by another can disinhibit a reluctant youngster.
- Pairing a reluctant youngster with a supportive peer or small group can help.
- Train and use others (aides, volunteers, peers) to (1) enter into productive (nonconfidential) dialogues that help clarify the youngster's perceptions and then (2) share the information with you in the best interests of helping.
- For youngsters who can't seem to convey their thoughts and feelings in words, their behavior often says a lot about their views; based on your observations and with the idea of opening a dialogue, you can share your perceptions and ask if you are right.
- Sometimes a list of items (e.g. things that they like/don't like to do at school/after school) can help elicit views and open up a dialogue.
- When youngsters have learning, behavior, and emotional problems, find as many ways as feasible to have positive interchanges with them and make positive contacts outweigh the negatives.
- ***Remember**:* Short periods of silence are part of the process and should be accommodated.

BEST COPY AVAILABLE

Outline and Discuss What Has Been Learned so Far

(1) Use this worksheet to briefly clarify how you understand the various reasons students might have learning, behavioral, and emotional problems.

(2) Share your thoughts about this informally with colleagues/friends or in a study group.

(3) In what ways did the discussion lead to changes in your initial response?

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 824-3634; smhp@ucla.edu

Interviewing to Determine a Student's View of the Problem

(1) Review "Student's View of the Problem" forms in *School-Based Client Consultation, Referral, and Management of Care* (pp. 54 - 59)

(2) Note below your view of the role of teachers and school support staff should play in exploring students problems from the student's perspective.

(3) Interview a student who is having problems or role-play with a colleague/friend.

(4) In what ways might such an interview assist school staff in better understanding how to address barriers to student learning?

•

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 824-3634; smhp@ucla.edu

Mental Health in Schools
Center
Training and Technical Assistance

Excerpt From

*From the Center's Clearinghouse ...**

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This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website (http://smhp.psych.ucla.edu)

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Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

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(For use with all but very young students)

Student's View of the Problem -- Initial Interview Form

Interviewer ____________________ Date____________

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

Questions for student to answer:

Student's Name ____________________________ Age _____ Birthdate ___________

Sex: M F Grade _______ Current Placement ____________________

Ethnicity _________ Primary Language __________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) How would you describe your current situation? What problems are you experiencing? What are your main concerns?

(2) How serious are these matters for you at this time?

1 very serious	2 serious	3 Not too serious	4 Not at all serious

(3) How long have these been problems?

___ 0-3 months ___4 months to a year ____more than a year

(4) What do you think originally caused these problems?

(5) Do others (parents, teachers, friends) think there were other causes?
If so, what they say they were?

(6) What other things are currently making it hard to deal with the problems?

(7) What have you already tried in order todeal with the problems?

(8) Why do you think these things didn't work?

(9) What have others advised you to do?

(10) What do you think would help solve the problems?

(11) How much time and effort do you want to put into solving the problems?

1	2	3	4	5	6
not at all	not much	only a	more than little bit	quite a bit a little bit	very much

If you answered 1, 2, or 3, why don't you want to put much time and effort into solving problems?

(12) What type of help do you want?

(13) What changes are you hoping for?

(14) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(15) What else should we know so that we can help?

Are there any other matters you want to discuss?

(For use with very young students)

Student's View of the Problem -- Initial Interview Form

Interviewer ______________________ Date ______________

Note the identified problem:

Is the student seeking help? Yes No

If not, what were the circumstances that brought the student to the interview?

Questions for student to answer:

Student's Name ________________________________ Age _____ Birthdate ___________

Sex: M F Grade ________ Current Placement ______________________

Ethnicity __________ Primary Language ___________________

We are concerned about how things are going for you. Our talk today will help us to discuss what's going O.K. and what's not going so well. If you want me to keep what we talk about secret, I will do so -- except for those things that I need to discuss with others in order to help you.

(1) Are you having problems at school? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(2) How much do you like school?

1	2	3	4	5	6
not at all	not much	only a little bit	more than a little bit	Quite a bit	Very much

What about school don't you like?

What can we do to make it better for you?

(3) Are you having problems at home? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(4) How much do you like things at home?

1	2	3	4	5	6
not at all	not much	only a	more than a little bit	Quite a bit little bit	Very much

What about things at home don't you like?

What can we do to make it better for you?

(5) Are you having problems with other kids? ___Yes ___No
If yes, what's wrong?

What seems to be causing these problems?

(6) How much do you like being with other kids?

1	2	3	4	5	6
not at all	not much	only a	more than a little bit	Quite a bit little bit	Very much

What about other kids don't you like?

What can we do to make it better for you?

(7) What type of help do you want?

(8) How hopeful are you about solving the problems?

1	2	3	4
very hopeful	somewhat	not too	not at all hopeful

If you're not hopeful, why not?

(9) What else should we know so that we can help?

Are there any other things you want to tell me or talk about?

Review Screening Tools

Attached is an introduction to a Resource Aid Packet entitled:

Screening/Assessing Students: Indicators and Tools

Go to the Center website – http://smhp.psych.ucla.edu to review the material and download any of the resources you see as potentially useful.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 824-3634; smhp@ucla.edu.

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Indicators and Tools

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Appendix. Excerpt from ***Nursing Assessment of School Age Youth: A Series of Self Study Modules*** 91

I. Screening

A. Screening: A Note of Caution

Formal screening to identify students who have problems or who are "at risk" is accomplished through individual or group procedures. Most such procedures are *first-level* screens and are expected to *over identify* problems. That is, they identify many students who do not really have significant problems (false positive errors). This certainly is the case for screens used with infants and primary grade children, but false positives are not uncommon when adolescents are screened. Errors are supposed to be detected by follow-up assessments.

Because of the frequency of false positive errors, serious concerns arise when screening data are used to diagnose students and prescribe remediation and special treatment. Screening data primarily are meant to sensitize responsible professionals. No one wants to ignore indicators of significant problems. At the same time, there is a need to guard against tendencies to see *normal variations* in student's development and behavior as problems.

Screens do not allow for definitive statements about a student's problems and need. At best, most screening procedures provide a preliminary indication that something may be wrong. In considering formal diagnosis and prescriptions for how to correct the problem, one needs data from assessment procedures that have greater validity.

It is essential to remember that many factors found to be symptoms of problems also are common characteristics of young people, especially in adolescence. This means *extreme caution* must be exercised to avoid misidentifying and inappropriately stigmatizing a youngster. *Never* overestimate the significance of a few indicators.

I. Screening

B. The Debate about Screening – the pros and the cons

Should schools use behavioral screening to find `at risk' children?

Excerpted from Insight on the News. Oct. 4, 1999.

By James M. Kauffman.
www.findarticles.com/cf_0/m1571/37_15/56182669/print.jhtml

"...Most teachers know which students probably are headed for trouble...

Teachers do better in identifying high-risk youngsters of any age when they have a systematic way of describing kids' behavior and know just what to look for. The most accurate and reliable behavioral screening methods rely on teacher judgments guided by rating and observation instruments that have been field-tested...

Every screening device produces some errors: false positives and false negatives. A false positive means the screening identifies someone it shouldn't have; a false negative means someone who should have been identified was overlooked...

We don't want to identify more students for special services; we already serve too many. If you want to prevent problems, then you have to identify more kids – address problems earlier, which inevitably means identifying more students than we do now, when we wait for the problems to get out of hand..."

Kauffman, a former elementary-school teacher,
is Charles S. Robb Professor of Education
at the University of Virginia and
coeditor of the journal, Behavioral Disorders.

Topic 3: When should the school refer students and families to community resources?

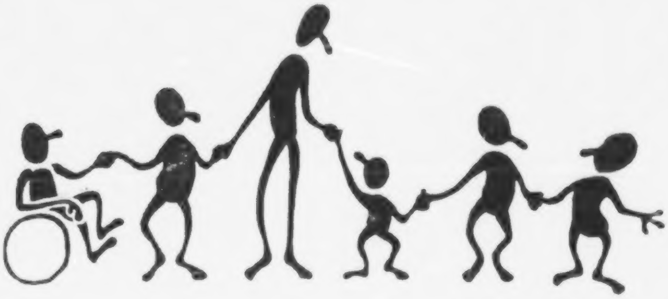
Reading & Activity

Reading. From: *School-Based Client Consultation, Referral, and Management of Care* (pp 12 - 37)

Activity. Use the various attached materials as stimuli and tools to focus application of what has been read.

(1) *Write and Discuss* – Using Pre-referral Interventions (use the attached worksheet as an activity guide)

(2) *Write and Discuss* – Referral Intervention Guidelines (use the attached worksheet as an activity guide)



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Referral: More than Giving a Name and Address

Referrals for service are commonplace at school sites.

And, for the most part,

referrals are relatively easy to make.

BUT,

because most students are reluctant to follow-through on a referral, the process needs to go beyond simply giving a student (or family) a name and address.

Schools must develop effective referral *intervention* strategies.

That is, it is essential to have referral procedures in place that

- provide ready reference to information about appropriate referrals,
- maximize follow-through by using a *client consultation process* that involves students and families in all decisions and helping them deal with potential barriers.

Referrals should be based on (1) sound *assessment* (information about the client's needs and resources available) and (2) consumer-oriented *client consultation.* Although most assessment and consultation can be seen as a form of problem solving, such problem solving may or may not be an activity professionals share with clients.

In developing a consumer-oriented system, the intent is twofold:

- to provide consumers with ready access to information on relevant services
- to minimize abuses often found in professional referral practices.

At the same time, the hope is that a positive side effect will be a higher degree of client self-reliance in problem solving, decision making, and consumer awareness.

Referrals are easy to make . . .

An old fable tells of an arthritic Bulgarian peasant and her encounter with a doctor. After an extensive examination, he diagnoses her problems and writes a prescription for medication, details a special diet, and recommends that she have hydrotherapy. The doctor's professional manner and his expert diagnosis and prescription naturally filled the woman with awe, and as she leaves his office, she is overcome with admiration and says the Bulgarian equivalent of "Gee, you're wonderful doctor!"

A few years pass before the doctor runs into the woman again. As soon as she sees him, she rushes up and kisses his hand and thanks him again for his marvelous help. The doctor, of course, is gratified. Indeed, he is so pleased that he fails to notice that she is as crippled as before.

unfortunately, data suggest that follow-through rates for referrals made by staff at schools sites are under 50%.

The fact is that the woman never got the medication because she neither had the money nor access to an apothecary. Moreover, her village had no provision for hydrotherapy, and the prescribed diet included too many foods she either did not like or could not afford.

Nevertheless, despite her continuing pain, she remained full of awe for the wise doctor and praised him to everyone who would listen.

(Adapted from Berne, 1964)

To aid in reviewing client need and consideration of potential resources, information is presented in an organized and comprehensible manner. To facilitate decision making, guidance and support are provided in exploring the pros and cons of the most feasible alternatives. To encourage consumer self-protection, basic evaluative questions are outlined for consumers to ask of potential service providers before contracting for services.

> Toward meeting all these ends, the process must be one of shared or guided problem solving with the objective of helping consumers (usually students and parents together) arrive at their own decisions rather than passively adopting the professional's recommendations and referrals.

A consumer-oriented, guided problem-solving approach eliminates a number of problems encountered in prevailing approaches. The process avoids making "expert" and detailed prescriptions that go beyond the validity of assessment procedures; and it avoids referrals based on "old boy" networks by ensuring clients have direct access to a well-developed community resource referral file.

> As with all assessment involved in decision making, the *assessment* process has three major facets: (a) a rationale that determines what is assessed, (b) "measurement" or data gathering (in the form of analyses of records, observations, and personal perspectives, as well as tests when needed), and (c) judgments of the meaning of what has been "measured."

The *consultation* process also has three major facets: (a) a rationale that determines the focus of consultation activity, (b) exploration of relevant information (including "expert" information), and (c) decision making by the consumers.

An example of some specific steps used in an assessment and consultation process is provided on the next page.

Some Specific Steps in an Assessment and Consultation Process

(1) Initial screening of student/family (initial contacts with the home may be via phone conversations)

(2) Filling out of questionnaires by each concerned party (parents and student) regarding his or her perception of the cause of identified problems and their correction

(3) Gathering records and reports from other professionals or agencies when consumers agree it might be useful

(4) Brief, highly circumscribed testing, if necessary and desired by consumers

(5) Initial review of assessment findings to determine if enough information is available to proceed with client consultation

(6) Holding group conference(s) with immediately concerned parties to

- analyze problems and in the process to review again whether other information is needed (and if so to arrange for gathering it)
- arrive at an agreement about how a problem will be understood for purposes of generating alternatives
- generate, evaluate, and make decisions about which alternatives to pursue
- formulate plans for pursuing alternatives (designating support strategies to ensure follow-through)

(7) Follow-up via telephone or conference to evaluate the success of each pursued alternative and determine satisfaction with the process

Problem analysis and decision making can be accomplished in a session. However, if additional assessment data are needed, one or two assessment sessions and a subsequent conference are required.

Because some people have come to overrely on experts, some clients may be a bit frustrated when they encounter an approach such as the one just described. They want professionals to give a battery of tests that will provide definitive answers, and they want decisions made for them. (They are convinced they cannot make good decisions for themselves.) These individuals often are a product of the negative side effects of professional practices that mystify consumers and make them feel totally dependent on professionals.

Managing *Care,* Not *Cases*

Common terminology designates those whom professionals work with as "cases." Thus, considerations about making certain that clients connect with referral resources often are discussed as "case monitoring" and efforts to coordinate and integrate interventions for a client are designated "case management."

At the same time, efforts to ensure there are comprehensive and integrated resources to assist clients often refer to the expansion of "systems of care."

Given that words profoundly shape the way people, think, feel, and act, some professionals are arguing for use of the term "care" in place of "case." Such a move is in keeping with the view that care is a core value of helping professionals. It also is consistent with the growing emphasis on ensuring that schools are "caring communities." For these reasons, it seems appropriate to replace the term case management with that of *management of care.*

The focus in Section II of this technical resource aid is on principles and procedures to guide establishment of a comprehensive referral intervention. The perspective taken in developing such an intervention is that it should be consumer oriented and user friendly.

Section II

Referral as an Intervention

Referral: A Transition Intervention

The Prereferral Process: A Guide

The Referral Process: Some Guidelines and Steps

Providing Information About Services

Developing Ways to Facilitate Access to Service

- Highlighting the Most Accessible Referral Resources
- Referral Resource Files
- Support and Direction for Follow-through
- Personal Contact with Referral Resources
- Enhancing On-Campus Services

Follow-up on Referrals (including consumer feedback)

Referral as an Intervention

It is important to remember that referral is an intervention. Because it involves decisions about how to move from what is currently happening to a better state of affairs, it can be viewed as transition intervention.

Referral: A Transition Intervention

The referral process begins when someone identifies a problem and asks for help. Sometimes assistance can be given at this point so that the student does not need referral to special services. This type of assistance is often called *prereferral intervention.* Actually, it is the first and sometimes a sufficient phase of the referral process. The assessment data generated during this process also is useful in making triage decisions.

On the following pages is a resource aid to guide school-based efforts to plan and implement a *prereferral process.*

A guide for teachers and other school staff regarding . . .

The Prereferral Process

When a student is seen as having problems, the following steps may be helpful.

Related guidelines and materials are attached.

Step 1: Based on your work with the student, *formulate a description* of the student's problem.

Step 2: Have *a discussion* to get the student's view. You may want to include the family.

Step 3: Try *new strategies* in the classroom based on your discussion.

Step 4: If the new strategies don't work, *talk to others* at school to learn about additional approaches they have found helpful.

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Step 1: Based on your work with the student, *formulate a description* of the student's problem (use the checklist as an aid) and then request a Triage Review (see Appendix A).

A Checklist to Aid in Describing the Problem

Teacher's Name: ____________________ Rm. _______ Date__________

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. If a student is having a significant learning problem or is misbehaving or seems extremely disturbed, begin by checking off those items below that are concerning you.

Student's name:________________ Birth date: _________ Grade: _____

Social Problems
( ) Aggressive
( ) Shy
( ) Overactive
( ) _______________

Achievement problems
( ) Poor skills
( ) Low motivation
( ) ______________________

Overall academic performance
( ) Above grade level
( ) At grade level
( ) Slightly below grade level
( ) Well below grade level

Absent from school
( ) Less than once/month
( ) Once/month
( ) 2-3 times/month
( ) 4 or more times/month

Other specific concerns:

Comments: If you have information about what is causing the problem, briefly note the specifics here.

Step 2: Have a discussion to get the student's view. You may want to include the family. (See suggestions below).

Exploring the Problem with the Student and Family

As you know the causes of learning, behavior, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be an emotionally-based problem; behavior problems often arise in reaction to learning difficulties; what appears as a school problem may be the result of a problem at home.

> It is particularly hard to know the underlying cause of a problem when the student is unmotivated to learn and perform. It will become clearer as you find ways to enhance the student's motivation to perform in class and talk more openly with you.

The following guide is to help you get a more information about a student's problem.

Make personal contact with student (and those in the home). Try to improve your understanding of why the student is having problems and see if you can build a positive working relationship. Special attention should be paid to understanding and addressing factors that may affect the student's intrinsic motivation to learn and perform.

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).
2. Ask about outside interests and "hobbies."
3. Ask about what the student doesn't like at school and in the class.
4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)
5. Explore what other factors the student and those in the home think may be causing the problem?
6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).
7. Discuss some new things the student and those in the home would be *willing* to try to make things better.

See student interview form in Appendix A.

Step 3: Try new strategies in the classroom based on your discussion.

Some Things to Try

The following list is meant as a stimulus to suggest specific strategies to try before referring a student for special help.

1. Make changes to (a) improve the match between a student's program and his/her interests and capabilities and (b) try to find ways for the student to have a special, positive status in the program, at the school, in the community. Talk and work with other staff in developing ideas along these lines.
2. Add resources for extra support (aide, volunteers, peer tutors) to help student's efforts to learn and perform. This includes having others cover your duties long enough for you to interact and relate with student as an individual.
3. Discuss with student (and those in the home) why the problems are occurring
4. Special exploration with student to find ways to enhance positive motivation
5. Change regular program/materials/environment to provide a better match with student's interests and skills
6. Provide enrichment options in class and as feasible elsewhere
7. Use volunteers/aide/peers to enhance the student's social support network
8. Special discussion with those in the home to elicit enhanced home involvement in solving the problem
9. Hold another special discussion with the student at which other staff (e.g., counselor, principal) join in to explore reasons for the problem and find ways to enhance positive motivation

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Step 4: If the new strategies don't work, talk to others at school to learn about additional approaches they have found helpful.

- Reach out for support/mentoring/coaching
- Participate with others in clusters and teams
- Observe how others teach in ways that effectively address differences in student motivation and capability
- Request additional staff development on working with students who have learning, behavior, and emotional problems

With respect to staff development, there are a variety of topics that might be pursued. These include:

- addressing barriers to learning within the context of a caring, learning community
- ways to train aides, volunteers, and peers to help with targeted students
- specific strategies for mobilizing parent/home involvement in schooling
- using specialist staff for in-class and temporary out-of-class help
- addressing the many transition needs of students.

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Teacher Assistance Teams

One prereferral method uses teacher assistance teams (TATs) which also go by such labels as staff support teams, intervention assistance teams, etc. Stokes (1982) defines a TAT as "a school based problem-solving group whose purpose is to provide a vehicle for discussion of issues related to specific needs of teachers or students and to offer consultation and follow-up assistance to staff..." TATs are typically comprised of regular classroom, teachers; however, in some settings, TATs also include representatives from multiple disciplines, such as psychology or special education. TATs focus on intervention planning, usually prior to referral and assessment, rather than on placement. The TAT and the referring teacher meet to discuss problems the student is having, think of possible solutions, and develop a plan of action to be implemented by the referring teacher. Assessment data are gathered by TATs for the purpose of planning and monitoring the effectiveness of interventions. Follow-up meetings are held to discuss the effectiveness of the proposed interventions, and to develop other strategies if necessary. Ultimately, the TAT decides whether the student should be referred to special education (Garcia & Ortiz, 1988).

References

Stokes, S. (1982). *School-based staff support teams: A blueprint for action.* Reston, VA: Council for Exceptional Children.

Garcia, S.B., & Ortiz, A.A. (1988). *Preventing inappropriate referrals of language minority students to special education. Occasional Papers in Bilingual Education. NCBE New Focus #5.* Silver Spring, MD: National Clearinghouse for Bilingual Education (EDRS # ED309591).

The Referral Process: Some Guidelines and Steps

Effective referral *intervention* strategies involve procedures that

- provide ready reference to information about appropriate referrals
- maximize follow-through by helping students and families make good decisions and plan ways to deal with potential barriers.

A client oriented, user friendly referral intervention is built around recognition of the specific needs of those served and involves clients in every step of the process. That is, the intervention is designed with an appreciation of

- the nature and scope of student problems as perceived by students and their family
- differences among clients in terms of background and resources
- the ethical and motivational importance of client participation and choice.

Moreover, given that many clients are reluctant to ask for or follow-through with a referral, particular attention is paid to ways to overcome factors that produce reluctance.

Referral Intervention Guidelines

A referral intervention should minimally

- provide readily accessible basic information about all relevant sources of help
- help the student/family appreciate the need for and value of referral
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families to review their options and make decisions in their own best interests
- provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource
- follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

These guidelines can be translated into a 9 step intervention designed to facilitate the referral process and maximize follow-through.

Steps*

Step 1

Provide ways for students and school personnel to learn about sources of help without having to contact you

This entails widespread circulation to students/families and staff of general information about available services on- and off-campus and ways students can readily access services.

Step 2

For those who contact you, establish whether referral is necessary

It is necessary if school policy or lack of resources prevent the student's problem from being handled at school.

Step 3

Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Appendix B for more on the idea of a Referral Resource File).

Step 4

Analyze options with client and help client choose the most appropriate ones

This mainly involves evaluating the pros and cons of potential options (including location and fees), and if more than one option emerges as promising, rank ordering them.

Step 5

Identify and explore with the client all factors that might be potential barriers to pursuing the most appropriate option

Is there a financial problem? a transportation problem? a parental or peer problem? too much anxiety/fear/apathy?

(cont.)

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*Before pursuing such steps, be certain to review school district policies regarding referral (see Appendix B).

STEPS (cont.)

Step 6

Work on strategies for overcoming barriers

This often overlooked step is essential if referral is to be viable. It entails taking time to clarify specific ways the student/family can deal with factors likely to interfere with follow-through.

Step 7

*Send clients away with a written summary of what was decided**

That is, summarize

*specific information on the chosen referral,
*planned strategies for overcoming barriers,
*other options identified as back-ups in case
the first choice doesn't work out.

Step 8

*Provide client with follow-through status forms**

These are designed to let the school know whether the referral worked out, and if not, whether additional help is needed in connecting with a service.

Step 9

*Follow-up with students/families (and referrers) to determine status and whether referral decisions were appropriate**

This requires establishing a reminder system to initiate a follow-up interview after an appropriate time period.

Obviously, the above steps may require one or more sessions.

If follow-up indicates that the client hasn't followed-through and there remains a need, the referral intervention can be repeated, with particular attention to barriers and strategies for overcoming them. Extreme cases may require extreme measures such as helping a family overcome transportation problems or offering to go with a family to help them connect with a referral.

*See Appendix C for examples of tools to aid these steps.

Providing Information about Services

Whether you are in a situation with few or many referral options, it is essential to compile and share basic information about all potential services (see Appendix B). A prerequisite for establishing and updating a good referral information system is to identify a staff member who will accept ongoing responsibility for the system.

> Initially, such activity may take 3-4 hours a week. Maintaining the system probably requires only 1-2 hours per month. The staff member in charge of the system does not need to carry out all the tasks. Much of the activity can be done by a student or community volunteer or an aide.

In gathering information about services, the focus is on clarifying what is offered

- at the school site,
- elsewhere by school district personnel,
- in the local community,
- outside the immediate community.

> If the school does not have a list of on-campus resources, a first step is to survey school staff and prepare a list of on-campus services dealing with psychosocial and mental health concerns (see Appendix B).

Similarly, information about other services offered by the school district can be gathered by calling relevant district personnel (e.g., administrators in charge of school psychologists, social workers, health services, special education, counseling).

> In some geographic areas, public agencies (e.g., department of social services, libraries, universities) publish resource guidebooks which list major helplines, crises centers, mental health clinics, drug abuse programs, social service agencies, organizations offering special programs such as weight management, and so forth. Also, in some areas, telephone directories contain special sections on local Human Services.

Developing Ways to Facilitate Access to Service

In carrying out referral interventions to facilitate access to services, it is useful to develop

- materials listing the most accessible referrals and ways to circulate such materials widely,
- a comprehensive referral resource file,
- an array of procedures to support and direct students in following-through on referrals.
- And, it also may be useful to make personal contact with individuals at various agencies and programs as a way of opening doors for students referred from the school.

(1) *Highlighting the Most Accessible Referral Resources*

Once the most accessible referrals are identified, they can be listed and the lists can be widely circulated (see Appendix H for examples). Such listings might take the form of

- 1-2 page handouts,
- wallet-size handouts,
- program description flyers & posters.

To ensure widespread circulation, information on services first can be distributed to all school staff (preferably with a memo from the school administration clarifying the purposes and importance of referring students in need). A follow-up presentation at a school staff meeting is highly desirable.

> For older students, staff can offer to make direct presentations -- at least in classrooms of teachers who play a key role in distributing such information to students (e.g., homeroom or health teachers).

Because of staff changes, new enrollments, and the need for reminders, service information materials might be circulated at least three times during the school year. If the school has a health fair, this provides an excellent opportunity for disseminating service information material along with other relevant pamphlets. Such information also might be published in student newspapers and parent newsletters and as part of periodic health exhibits in school display cases and in health, counseling, and other offices.

(2) *Referral Resource Files*

A referral resource filing system is intended to contain a comprehensive compilation of basic information on available services (see Appendix B).

Sources for this information are published directories or material gathered directly from programs and agencies. For example, once identified, each service can be asked to provide all relevant program descriptions and information which can be filed alphabetically in separate folders.

Referral files are most useful when the basic information on available services also is categorized. Minimally, categorization should be by location and by the type of problems for which the service can provide help.

To further facilitate access, the information on each program can be briefly summarized and placed in a binder "Resource Notebook" for easy reference. Minimally, a program summary might itemize

- service fees (if any) and hours
- whether provision is made for clients who do not speak English
- specific directions to locations (if off-campus, it is helpful to specify public transportation directions).

Referral resource files should be located where interested students can use them on their own if they so desire. To facilitate unaided use, a set of simple directions should be provided, and files and "Resource Notebooks" need to be clearly labeled.

(3) *Support and Direction for Follow-through*

Many students are uncertain or not highly motivated to follow-through with a referral; others are motivated to avoid doing so. If we are to move beyond the ritual of providing referrals which students ignore, time and effort must be devoted to procedures that increase the likelihood of follow-through.

This involves finding out:

Does the student agree that a referral is necessary? (See student interview form in Appendix A.)

If not, additional time is required to help the student explore the matter. Uncertain students often need more information and should be offered the opportunity to meet with someone (e.g., school counselor, nurse, psychologist) who can explain about available programs. This includes discussing concerns about parental involvement. If such exploration does not result in the student really wanting to pursue a referral, follow-through on her or his own is unlikely. The problem then is whether the student's problem warrants coercive action (e.g., recruiting parents to take the student to the service).

For students who do agree that referral is appropriate but still are not highly motivated to follow-through, intervention focuses on increasing their motivation and providing support as they proceed.

Student participation in the process of identifying and choosing referral options is seen as one key to increasing motivation for follow-through. Students who feel the choice of where to go is theirs are likely to feel more committed. This is a good reason for working closely with a student at each step in identifying referral options.

Another aspect of enhancing a student's resolve to pursue a referral involves clarifying and addressing any reluctance, concern, and barriers through

- careful exploration of such factors
- specification of strategies to deal with them.

At the conclusion of the referral session(s), a potential enabling device is to provide the student with

- a written summary of referral recommendations and strategies for overcoming barriers

- two follow-up feedback forms -- one for the student to return to the school and one for the referral agency to send back.

  See Appendix C for examples.

Other major supports that might be offered students include

- helping them make initial phone contacts and appointments (including having the student talk directly with the person to be seen)

- providing specific directions and even transportation to the first appointment

- parents or staff accompanying a student to the first appointment

- following-up (as described in a subsequent section).

(4) *Personal Contact with Referral Resources*

Some staff have found that their referrals receive better attention after they have established a personal relationship with someone in a program or at an agency.

They accomplish this by periodically phoning and visiting or inviting selected individuals to visit.

In addition to helping establish special relationships that can facilitate access for students referred by the school, these contacts also provide additional information for referral resource files.

When Can Students Seek Assistance without Parent Involvement?

Older students often want or need to access services without their parents knowing and with confidentiality protected. Where the law allows, licensed professionals can offer some sensitive services without parent consent. School-based health centers allow for open access once parents have signed an initial consent form that allows the student to use designated services.

In many instances, however, students are not in a position or motivated to follow-through with a referral -- even though their problems may be severe. Thus, more often than not, parent involvement is needed to facilitate follow-through. For example, students may need parents to pay fees and for transportation. If a student is not an emancipated minor, the referral resource will probably require parental consent.

When parent involvement is indicated, the referral intervention includes efforts to help students understand the benefits of such involvement and encourage them to discuss the matter with their parents. Staff can play a major role in facilitating and perhaps mediating a student-parent discussion for students who see the need but are fearful of approaching their parents without support.

What if a student is determined not to involve parents? Except when inaction would place the student or others in extreme danger, some staff prefer to honor a student's desire to maintain confidentiality. In such instances, the only course of action open is to offer whatever referral follow-through support the school can provide. Some staff, however, believe it essential for parents to take responsibility for student follow-through. Thus, parents are given referral information and asked to see that the student makes contact. Any needed follow-through support is directed at the parents.

(5) *Enhancing On-Campus Services*

It is given that referral to services offered on-campus ensures accessibility and generally increases follow-through. Therefore, efforts to expand on-campus resources are important to improving follow-through.

Additional on-campus resources can be accomplished by

- recruiting and training interested school personnel and students to offer appropriate services (e.g., mediating, mentoring, counseling)
- outreaching to convince appropriate agencies and professionals to offer certain services on-campus (e.g., arranging for on-campus substance abuse counseling by personnel from county mental health or a local community mental health clinic)
- outreaching to recruit professionals-in-training and professional and lay volunteers
- helping create new programs (e.g., stimulating interest in starting a suicide prevention program and helping train school staff to run it).

CASE EXAMPLE

A 10th grader comes to see you because her home situation has become so distressful she cannot concentrate on her school work, and she is feeling overwhelmed. It's evident she needs support and counseling. Because the school cannot currently provide such services, she has to be referred elsewhere. Thus, it falls to someone at the school to implement a referral intervention. The immediate intervention might be conducted over two sessions, with a follow-up interview done 2 weeks later. The gist of the intervention might take the following form.

Session 1: *Sara, you've been very open in talking with me about the problems you're having at home. It sounds like some regular counseling appointments might help you sort things out.*

Right now, we can't provide what you need. Because it's important to take care of the problems you've told me about, I want to help you find someone who can offer what you need.

Let's look over what's available. (Referral Resource Files are used -- see Appendix B) *We have this information about local counseling resources. The first lists services provided by neighborhood agencies. There are two that might work for you. You said one of the problems is that your father drinks too much. As you can see, one local counseling center is doing a weekly group for Children of Alcoholics who want to talk about their troubles at home. And, on Wednesday afternoons, a social worker from a community center comes to the school to offer individual counseling.*

Not too far away is a counseling program offered by the school district. What might work for you is one of their counseling groups. These are offered on either Tuesday or Thursday after school at a place which is about 3 miles from here.

The program offered here at the school and the one provided by the school district are free; the one at the local counseling center charges a fee of $5 for each session. Both the school district's program and the local counseling center are on the bus line so you could get there on your own.

Why don't you take tonight to think about what might work best for you and maybe make a list of concerns you have that we should talk about. Think about how you feel about meeting with a counselor alone or working with other students in a support group. You may want to talk to your parents before you decide, but you don't have to. However, if you do want counseling, your parents will have to give their consent.

Let's meet again tomorrow to discuss your options and how I can help you make your decision.

(cont. on next page)

CASE EXAMPLE (cont.)

The second session focuses on Sara's (a) anxiety about telling her father she wants to sign up for counseling, (b) concerns about whether to join a group, and (c) preference not to go to an off-campus service. Any other barriers that might hinder follow-through also are worked on.

[After the various pros and cons are discussed and Sara seems to be favoring a particular option . . . .]

Session 2: *So it sounds as if you'd like to see the social worker who comes to campus every Wednesday. We should put that down as your first choice. You also said the Children of Alcoholics group might be worth checking out -- let's put that down as a second choice. . . . And as we agreed, I'll be glad to meet with you and your parents to help you explain that such counseling will be a good thing for you.*

Let's call your parents now and set up an appointment. . . . Tomorrow, you can call the social worker and make an appointment to talk about signing up for a regular counseling time. . . . If you have trouble with any of this, remember to come back to see me for help.

I've written all this down; here's your copy. (See Appendix A.) *I'd also like you to let me know how our plans work out. Here's a form for you to return to me; all you have to do is put a check mark to let me know what happened and then drop the form in the school mail box sometime next week.* (See Appendix C.)

Also, unless you need to come see me before then, I'll be checking with you in two weeks to see how things worked out.

Follow-up Interview: A "tickler" system (e.g., a notation on a calendar) is set up to provide a daily case monitoring reminder of who is due for a Follow-up Interview (discussed on the next page). The interview explores:

Has Sara been able to connect with her first or second choices?

If not, why not? And, how can she be helped to do so?

If she has made contact, does it now seem like the right choice was made? If not, the reasons why need to be clarified and additional options explored.

Following-Up on Referrals (including consumer feedback)

Follow-through for most referrals is meant to occur within a two week period. Thus, a good referral system should have a process in place that regularly reviews the status of students who were given referrals three weeks earlier.

The elements of such a system might include

- feedback forms given to clients for themselves and the referral agency (see Appendix D)
- a feedback form sent directly to the referral of first choice
- a procedure for daily identification of students due for referral follow-up
- analysis of follow-through status based on feedback
- follow-up interviews with students/families for whom there is no feedback information (See Appendix D).

For example:

As part of referral intervention, students/families can be given two types of feedback follow-up forms. In addition, a "back-up" feedback form can be sent directly to the service the student has identified as a first choice.

The client is to return a form to the school to show that contact was made with the referral agency or to clarify why such contact was not made. In either instance, the form reminds the student/family to return for additional referral help if needed.

If contact was made, the student/family might be asked to indicate whether the service seems satisfactory. For anyone who indicates dissatisfaction, the school may want to discuss the matter to determine whether another option should be pursued. If many clients indicate dissatisfaction with a particular agency, it becomes clear that it is not a good resource and should be removed from the referral listings.

The feedback form sent directly to the chosen service simply calls for a confirmation of follow-through. (With on-campus referrals, it has been found useful to establish a reciprocal feedback system. (See Appendix D.)

If no feedback forms are returned, the student can be invited to explore what happened and whether additional support and direction might help.

Worksheet

Write and Discuss

Using Pre-referral Interventions

(1) Review the section on "Pre-referral Process" in *School-Based Client Consultation, Referral, and Management of Care* (pp. 19 - 23).

(2) Make some brief notes on what you already do and what strategies you probably will add.

(3) Share your thoughts about this informally with colleagues/friends or in a study group.

(4) In what ways did the discussion lead to changes in your initial response?

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 824-3634; smhp@ucla.edu.

Mental Health in Schools
Center
Training and Technical Assistance

*From the Center's Clearinghouse ...**

A Technical Aid Packet on

School-Based Client Consultation, Referral, and Management of Care

This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website (http://smhp.psych.ucla.edu)

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A guide for teachers and other school staff regarding . . .

The Prereferral Process

When a student is seen as having problems, the following steps may be helpful.

Related guidelines and materials are attached.

Step 1: Based on your work with the student, *formulate a description* of the student's problem.

Step 2: Have *a discussion* to get the student's view. You may want to include the family.

Step 3: Try *new strategies* in the classroom based on your discussion.

Step 4: If the new strategies don't work, *talk to others* at school to learn about additional approaches they have found helpful.

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Step 1: Based on your work with the student, *formulate a description* of the student's problem (use the checklist as an aid) and then request a Triage Review (see Appendix A).

A Checklist to Aid in Describing the Problem

Teacher's Name: ____________________ Rm. _______ Date__________

Extensive assessment is not necessary in initially identifying a student about whom you are concerned. If a student is having a significant learning problem or is misbehaving or seems extremely disturbed, begin by checking off those items below that are concerning you.

Student's name:________________ Birth date: _________ Grade: _____

Social Problems
( ) Aggressive
( ) Shy
( ) Overactive
( ) _______________

Overall academic performance
( ) Above grade level
( ) At grade level
( ) Slightly below grade level
( ) Well below grade level

Achievement problems
( ) Poor skills
( ) Low motivation
( ) _____________________

Absent from school
( ) Less than once/month
( ) Once/month
( ) 2-3 times/month
( ) 4 or more times/month

Other specific concerns:

Comments: If you have information about what is causing the problem, briefly note the specifics here.

Step 2: Have a discussion to get the student's view. You may want to include the family. (See suggestions below).

Exploring the Problem with the Student and Family

As you know the causes of learning, behavior, and emotional problems are hard to analyze. What looks like a learning disability or an attentional problem may be an emotionally-based problem; behavior problems often arise in reaction to learning difficulties; what appears as a school problem may be the result of a problem at home.

> It is particularly hard to know the underlying cause of a problem when the student is unmotivated to learn and perform. It will become clearer as you find ways to enhance the student's motivation to perform in class and talk more openly with you.

The following guide is to help you get a more information about a student's problem.

> Make personal contact with student (and those in the home). Try to improve your understanding of why the student is having problems and see if you can build a positive working relationship. Special attention should be paid to understanding and addressing factors that may affect the student's intrinsic motivation to learn and perform.

1. Starting out on a positive note: Ask about what the student likes at school and in the class (if anything).
2. Ask about outside interests and "hobbies."
3. Ask about what the student doesn't like at school and in the class.
4. Explore with the student what it is that makes the things disliked (e.g., Are the assignments seen as too hard? Is the student embarrassed because others will think s/he does not have the ability to do assignments? Do others pick on the student? Are the assignments not seen as interesting?)
5. Explore what other factors the student and those in the home think may be causing the problem?
6. Explore what the student and those in the home think can be done to make things better (including extra support from a volunteer, a peer, etc.).
7. Discuss some new things the student and those in the home would be *willing* to try to make things better.

See student interview form in Appendix A.

Step 3: Try new strategies in the classroom based on your discussion.

Some Things to Try

The following list is meant as a stimulus to suggest specific strategies to try before referring a student for special help.

1. Make changes to (a) improve the match between a student's program and his/her interests and capabilities and (b) try to find ways for the student to have a special, positive status in the program, at the school, in the community. Talk and work with other staff in developing ideas along these lines.

2. Add resources for extra support (aide, volunteers, peer tutors) to help student's efforts to learn and perform. This includes having others cover your duties long enough for you to interact and relate with student as an individual.

3. Discuss with student (and those in the home) why the problems are occurring

4. Special exploration with student to find ways to enhance positive motivation

5. Change regular program/materials/environment to provide a better match with student's interests and skills

6. Provide enrichment options in class and as feasible elsewhere

7. Use volunteers/aide/peers to enhance the student's social support network

8. Special discussion with those in the home to elicit enhanced home involvement in solving the problem

9. Hold another special discussion with the student at which other staff (e.g., counselor, principal) join in to explore reasons for the problem and find ways to enhance positive motivation

Step 4: If the new strategies don't work, talk to others at school to learn about additional approaches they have found helpful.

- Reach out for support/mentoring/coaching
- Participate with others in clusters and teams
- Observe how others teach in ways that effectively address differences in student motivation and capability
- Request additional staff development on working with students who have learning, behavior, and emotional problems

With respect to staff development, there are a variety of topics that might be pursued. These include:

- addressing barriers to learning within the context of a caring, learning community
- ways to train aides, volunteers, and peers to help with targeted students
- specific strategies for mobilizing parent/home involvement in schooling
- using specialist staff for in-class and temporary out-of-class help
- addressing the many transition needs of students.

Step 5: If necessary, use the *school's referral processes* to ask for additional support services.

Step 6: Work with referral resources to *coordinate your efforts* with theirs for classroom success.

Write and Discuss

Using Referral Interventions

(1) Review the "Referral Intervention Guidelines" in the *School-Based Client Consultation, Referral and Management of Care* (pp. 26 - 28)

(2) Make some brief notes on what you already do and what strategies you probably will add

(3) Review survey: *Survey of System Status.* Note what is in place and what's missing.

(4) Share your thoughts about this informally with colleagues/friends or in a study group.

(5) In what ways did the discussion lead to changes in your initial response?

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Referral Intervention Guidelines

A referral intervention should minimally

- provide readily accessible basic information about all relevant sources of help
- help the student/family appreciate the need for and value of referral
- account for problems of access (e.g., cost, location, language and cultural sensitivity)
- aid students/families to review their options and make decisions in their own best interests
- provide sufficient support and direction to enable the student/family to connect with an appropriate referral resource
- follow-up with students (and with those to whom referrals are made) to determine whether referral decisions were appropriate.

These guidelines can be translated into a 9 step intervention designed to facilitate the referral process and maximize follow-through.

Steps*

Step 1

Provide ways for students and school personnel to learn about sources of help without having to contact you

This entails widespread circulation to students/families and staff of general information about available services on- and off-campus and ways students can readily access services.

Step 2

For those who contact you, establish whether referral is necessary

It is necessary if school policy or lack of resources prevent the student's problem from being handled at school.

Step 3

Identify potential referral options with the client

If the school cannot provide the service, the focus is on reviewing with the student/family the value and nature of referral options. Some form of a referral resource file is indispensable (see Appendix B for more on the idea of a Referral Resource File).

Step 4

Analyze options with client and help client choose the most appropriate ones

This mainly involves evaluating the pros and cons of potential options (including location and fees), and if more than one option emerges as promising, rank ordering them.

Step 5

Identify and explore with the client all factors that might be potential barriers to pursuing the most appropriate option

Is there a financial problem? a transportation problem? a parental or peer problem? too much anxiety/fear/apathy?

(cont.)

---

*Before pursuing such steps, be certain to review school district policies regarding referral (see Appendix B).

STEPS (cont.)

Step 6

Work on strategies for overcoming barriers

This often overlooked step is essential if referral is to be viable. It entails taking time to clarify specific ways the student/family can deal with factors likely to interfere with follow-through.

Step 7

*Send clients away with a written summary of what was decided**

That is, summarize

*specific information on the chosen referral,
*planned strategies for overcoming barriers,
*other options identified as back-ups in case the first choice doesn't work out.

Step 8

*Provide client with follow-through status forms**

These are designed to let the school know whether the referral worked out, and if not, whether additional help is needed in connecting with a service.

Step 9

*Follow-up with students/families (and referrers) to determine status and whether referral decisions were appropriate**

This requires establishing a reminder system to initiate a follow-up interview after an appropriate time period.

Obviously, the above steps may require one or more sessions.

If follow-up indicates that the client hasn't followed-through and there remains a need, the referral intervention can be repeated, with particular attention to barriers and strategies for overcoming them. Extreme cases may require extreme measures such as helping a family overcome transportation problems or offering to go with a family to help them connect with a referral.

*See Appendix C for examples of tools to aid these steps.

Mental Health in Schools Center Training and Technical Assistance

Excerpt From:

*From the Center's Clearinghouse . . .**

A Resource Aid Packet on

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What it Needs

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About the Self-Study Process to Enhance the Component for Addressing Barriers to Student Learning

This type of self-study is best done by teams.

However, it is *NOT* about having another meeting and/or getting through a task!

It is about moving on to better outcomes for students through

- working together to understand what is and what might be
- clarifying gaps, priorities, and next steps

Done right it can

- counter fragmentation and redundancy
- mobilize support and direction
- enhance linkages with other resources
- facilitate effective systemic change
- integrate all facets of systemic change and counter marginalization of the component to address barriers to student learning

A group of school staff (teachers, support staff, administrators) could use the items to discuss how the school currently addresses any or all of the areas of the component to address barriers (the enabling component). Members of a team initially might work separately in responding to survey items, but the real payoff comes from group discussions.

The items on a survey help to clarify
- what is currently being done and whether it is being done well and
- what else is desired.

This provides a basis for a discussion that

- analyzes whether certain activities should no longer be pursued (because they are not effective or not as high a priority as some others that are needed).
- decides about what resources can be redeployed to enhance current efforts that need embellishment
- identifies gaps with respect to important areas of need.
- establishes priorities, strategies, and timelines for filling gaps.

The discussion and subsequent analyses also provide a form of quality review.

Mapping System Status

As your school sets out to enhance the usefulness of education support programs designed to address barriers to learning, it helps to clarify what you have in place as a basis for determining what needs to be done. You will want to pay special attention to

- *clarifying what resources already are available*
- *how the resources are organized to work in a coordinated way*
- *what procedures are in place for enhancing resource usefulness*

This survey provides a starting point.

The first form provides a template which you can fill in to clarify the people and their positions at your school who provide services and programs related to addressing barriers to learning. This also is a logical group of people to bring together in establishing a resource-oriented team for the school.

Following this is a survey designed to help you review how well systems for Learning Supports have been developed and are functioning.

Resource Coordination **(names & schedules provided so staff, students, and families can access)**

Some of the Special Resources Available at ____________ School

In a sense, each staff member is a special resource for each other. A few individuals are highlighted here to underscore some special functions.

School Psychologist ______________________
times at the school ________________

- Provides assessment and testing of students for special services. Counseling for students and parents. Support services for teachers. Prevention, crisis, conflict resolution, program modification for special learning and/or behavioral needs.

School Nurse ______________________
times at the school ________________

- Provides immunizations, follow-up, communicable disease control, vision and hearing screening and follow-up, health assessments and referrals, health counseling and information for students and families.

Pupil Services & Attendance Counselor
____
times at the school ________________

- Provides a liaison between school and home to maximize school attendance, transition counseling for returnees, enhancing attendance improvement activities.

Social Worker ______________________
times at the school ________________

- Assists in identifying at-risk students and provides follow-up counseling for students and parents. Refers families for additional services if needed.

Counselors times at the school
________________ ________
________________ ________

- General and special counseling/guidance services. Consultation with parents and school staff.

Dropout Prevention Program Coordination
____
times at the school ________________

- Coordinates activity designed to promote dropout prevention.

Title I and Bilingual Coordinators
____
____

- Coordinates categorical programs, provides services to identified Title I students, implements Bilingual Master Plan (supervising the curriculum, testing, and so forth)

Resource and Special Education Teachers
____
____
____
times at the school ________________

- Provides information on program modifications for students in regular classrooms as well as providing services for special education.

Other important resources:

School-based Crisis Team (list by name/title)
__________/__________
__________/__________
__________/__________
__________/__________
__________/__________

School Improvement Program Planners
__________/__________
__________/__________
__________/__________

Community Resources

- Providing school-linked or school-based interventions and resources

Who	What they do	When

Survey of System Status

In discussing the following survey items, note:

Items 1-6 ask about what processes are in place.
Use the following ratings in responding to these items.

- DK = don't know
- 1 = not yet
- 2 = planned
- 3 = just recently initiated
- 4 = has been functional for a while
- 5 = well institutionalized (well established with a commitment to maintenance)

Items 7- 10 ask about effectiveness of existing processes.
Use the following ratings in responding to these items.

- DK = don't know
- 1 = hardly ever effective
- 2 = effective about 25 % of the time
- 3 = effective about half the time
- 4 = effective about 75% of the time
- 5 = almost always effective

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized

1. Is someone at the school designated as coordinator/leader for activity designed to address barriers to learning (e.g., education support programs, health and social services, the Enabling Component)? DK 1 2 3 4 5

2. Is there a time and place when personnel involved in activity designed to address barriers to learning meet together? DK 1 2 3 4 5

3. Do you have a Resource Coordinating Team? DK 1 2 3 4 5

4. Do you have written descriptions available to give staff (and parents when applicable) regarding DK 1 2 3 4 5

    (a) activities available at the site designed to address barriers to learning (programs, teams, resources services -- including parent and family service centers if you have them)? DK 1 2 3 4 5

    (b) resources available in the community? DK 1 2 3 4 5

    (c) a system for staff to use in making referrals? DK 1 2 3 4 5

    (d) a system for triage (to decide how to respond when a referral is made)? DK 1 2 3 4 5

    (e) a case management system? DK 1 2 3 4 5

    (f) a student study team? DK 1 2 3 4 5

    (g) a crisis team? DK 1 2 3 4 5

    (h) Specify below any other relevant programs/services -- including preventive approaches (e.g., prereferral interventions; welcoming, social support, and articulation programs to address transitions; programs to enhance home involvement in schooling; community outreach and use of volunteer)?

DK 1 2 3 4 5

______________________ DK 1 2 3 4 5

______________________ DK 1 2 3 4 5

______________________ DK 1 2 3 4 5

5. Are there effective processes by which staff and families learn DK 1 2 3 4 5

    (a) what is available in the way of programs/services? DK 1 2 3 4 5

    (b) how to access programs/services they need?

6. With respect to your complex/cluster's activity designed to address barriers to learning has someone at the school been designated as a representative to meet with the other schools? DK 1 2 3 4 5

DK = don't know
1 = not yet
2 = planned
3 = just recently initiated
4 = has been functional for a while
5 = well institutionalized

7. How effect is the

(a) referral system? DK 1 2 3 4 5

(b) triage system? DK 1 2 3 4 5

(c) case management system? DK 1 2 3 4 5

(d) student study team? DK 1 2 3 4 5

(e) crisis team? DK 1 2 3 4 5

8. How effective are the processes for

(a) planning, implementing, and evaluating system improvements (e.g., related to referral, triage, case management, student study team, crisis team, prevention programs)? DK 1 2 3 4 5

(b) enhancing resources for assisting students and family (e.g.,through staff development; developing or bringing new programs/services to the site; making formal linkages with programs/services in the community)? DK 1 2 3 4 5

9. How effective are the processes for ensuring that

(a) resources are properly allocated and coordinated? DK 1 2 3 4 5

(b) linked community services are effectively coordinated/integrated with related activities at the site? DK 1 2 3 4 5

10. How effective are the processes for ensuring that resources available to the whole complex/cluster are properly allocated and shared/coordinated? DK 1 2 3 4 5

Please list community resources with which you have formal relationships.

(a) Those that bring program(s) to the school site

(b) Those not at the school site but which have made a special commitment to respond to the school's referrals and needs.

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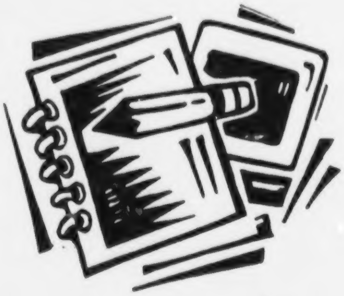
A Resource Aid Packet on

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What it Needs



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Surveying and Planning to Enhance Efforts to Address Barriers to Learning at a School Site

The following resource aides were designed as a set of self-study surveys to aid school staff as they try to map and analyze their current programs, services, and systems with a view to developing a comprehensive, multifaceted approach to addressing barriers to learning.

In addition to an overview Survey of System Status, there are status surveys to help think about ways to address barriers to student learning by enhancing

- classroom-based efforts to enhance learning and performance of those with mild-moderate learning, behavior, and emotional problems
- support for transitions
- prescribed student and family assistance
- crisis assistance and prevention
- home involvement in schooling
- outreach to develop greater community involvement and support--including recruitment of volunteers
- Finally, included is a special survey focusing on School-Community Partnerships.

Survey of Program Status
(Personalized Assistance)

Student and Family Assistance Programs and Services

The emphasis here is on providing special services in a personalized way to assist with a broad-range of needs. To begin with, available social, physical and mental health programs in the school and community are used. As community outreach brings in other resources, they are linked to existing activity in an integrated manner. Special attention is paid to enhancing systems for triage, case and resource management, direct services to meet immediate needs, and referral for special services and special education resources and placements as appropriate. Intended outcomes are to ensure special assistance is provided when necessary and appropriate and that such assistance is effective.

Please indicate all items that apply.	**Yes**	**Yes but more of this is needed**	**No**	**If no, is this something you want?**
A. Are there classroom focused enabling programs to reduce the need for teachers to seek special programs and services?	___	___	___	___
B. What activity is there to facilitate and evaluate requests for assistance?	___	___	___	___
1. Does the site have a directory that lists services and programs?	___	___	___	___
2. Is information circulated about services/programs?	___	___	___	___
3. Is information circulated clarifying how to make a referral?	___	___	___	___
4. Is information about services, programs, and referral procedures updated periodically?	___	___	___	___
5. Is a triage process used to assess				
a. specific needs?	___	___	___	___
b. priority for service?	___	___	___	___
6. Are procedures in place to ensure use of prereferral interventions?	___	___	___	___
7. Do inservice programs focus on teaching the staff ways to prevent unnecessary referrals?	___	___	___	___
8. Other? (specify) ______________________________	___	___	___	___
E. After triage, how are referrals handled?				
1. Is detailed information provided about available services (e.g., is an annotated community resource system available)?	___	___	___	___
2. Is there a special focus on facilitating effective decision making?	___	___	___	___
3. Are students/families helped to take the necessary steps to connect with a service or program to which they have been referred?	___	___	___	___

Student and Family Assistance Programs and Services (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethi you wan
D. What types of direct interventions are provided currently?				
1. Which medical services and programs are provided?				
a. immunizations				
b. first aid and emergency care				
c. crisis follow-up medical care				
d. health and safety education and counseling				
e. screening for vision problems				
f. screening for hearing problems				
g. screening for health problems (specify)				
h. screening for dental problems (specify)				
i. treatment of some acute problems (specify)				
j. other (specify) ____________________				
2. Which psychological services and programs are provided?				
a. psychological first aid				
b. crisis follow-up counseling				
c. crisis hotlines				
d. conflict mediation				
e. alcohol and other drug abuse programs				
f. pregnancy prevention program				
g. gang prevention program				
h. dropout prevention program				
i. physical and sexual abuse prevention				
j. individual counseling				
k. group counseling				
l. family counseling				
m. mental health education				
n. home outreach				
o. other (specify) ____________________				
3. Which of the following are provided to meet basic survival needs?				
a. emergency food				
b. emergency clothing				
c. emergency housing				
d. transportation support				
e. welfare services				
f. language translation				
g. legal aid				
h. protection from physical abuse				
i. protection from sexual abuse				
j. employment assistance				
k. other (specify) ____________________				

Student and Family Assistance Programs and Services (cont.)

	Yes	Yes but more of this is needed	No	If no, is this something you want?
4. Which of the following special education, Special Eligibility, and independent study programs and services are provided?				
a. early education program				
b. special day classes (specify) ______________________				
c. speech and language therapy				
d. adaptive P. E.				
e. special assessment				
f. Resource Specialist Program				
g. Chapter I				
h. School Readiness Language Develop. Program (SRLDP)				
i. other (specify) ______________________				
5. Which of the following adult education programs are provided?				
a. ESL				
b. citizenship classes				
c. basic literacy skills				
d. parenting				
e. helping children do better at school				
f. other (specify) ______________________				
6. Are services and programs provided to enhance school readiness? specify ______________________				
7. Which of the following are provided to address attendance problems?				
a. absence follow-up				
b. attendance monitoring				
c. first day calls				
8. Are discipline proceedings carried out regularly?				
9. Other? (specify) ______________________				
E. Which of the following are used to manage cases and resources?				
1. Is a student information system used?				
2. Is a system used to trail progress of students and their families?				
3. Is a system used to facilitate communication for				
a. case management?				
b. resource and system management?				
4. Are there follow-up systems to determine				
a. referral follow-through?				
b. consumer satisfaction with referrals?				
c. the need for more help?				
5. Other? (specify) ______________________				

Student and Family Assistance Programs (cont.)

	Yes	Yes but more of this is needed	No	If no, is this somethin you want
F. Which of the following are used to help enhance the quality and quantity of services and programs?				
1. Is a quality improvement system used?	___	___	___	___
2. Is a mechanism used to coordinate and integrate services/programs?	___	___	___	___
3. Is there outreach to link-up with community services and programs?	___	___	___	___
4. Is a mechanism used to redesign current activity as new collaborations are developed?	___	___	___	___
5. Other? (specify) ________________	___	___	___	___
G. What programs are used to meet the educational needs of personnel related to this programmatic area?				
1. Is there ongoing training for team members concerned with the area of Student and Family Assistance?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs (e.g., Assessment and Consultation Team, direct service providers)?	___	___	___	___
3. Other? (specify) ________________	___	___	___	___
H. Which of the following topics are covered in educating stakeholders?				
1. broadening understanding of causes of learning, behavior, and emotional problems	___	___	___	___
2. broadening understanding of ways to ameliorate (prevent, correct) learning, behavior, and emotional problems	___	___	___	___
3. developing systematic academic supports for students in need	___	___	___	___
4. what classroom teachers and the home can do to minimize the need for special interventions	___	___	___	___
5. enhancing resource quality, availability, and scope	___	___	___	___
6. enhancing the referral system and ensuring effective follow through	___	___	___	___
7. enhancing the case management system in ways that increase service efficacy	___	___	___	___
8. other (specify) ________________	___	___	___	___

Student and Family Assistance Programs (cont.)

I. Please indicate below any other ways that are used to provide student and family assistance to address barriers to students' learning.

J. Please indicate below other things you want the school to do to provide student and family assistance to address barriers to students' learning.